UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF COLORADO, et al.,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF SUSAN FANELLI

I, Susan Fanelli, declare as follows:

1. I am a resident of the State of California. I am over the age of 18 and have personal knowledge of all the facts stated herein, except to those matters stated upon information and belief; as to those matters, I believe them to be true. If called as a witness, I could and would testify competently to the matters set forth below.

2. I am the Chief Deputy Director of Health Quality and Emergency Response for the California Department of Public Health (CDPH).

3. In my current position, which I started in February 2022, I oversee the work of the various Centers within CDPH, including the Center for Preparedness and Response, the Center for Infectious Disease, and the Center for Laboratory Sciences. In this capacity, I work with Center Deputies to set policy direction, identify and remove barriers to program implementation, and evaluate program performance.

4. I have served in several executive leadership roles within CDPH's Directors Office over the years. I was appointed as the Chief Deputy Director in March 2018, served as Acting Director in July 2019, and as Assistant Director between May 2015 and March 2018. In these roles, I oversaw several cross-cutting functions including public affairs, quality improvement, public health accreditation, and emergency preparedness.

5. Having spent more than ten years in CDPH's Emergency Preparedness Office, including several years as the Deputy Director and Assistant Deputy Director, I have been involved in the public health and medical response to a large number of emergencies including H1N1, wildfires, Ebola, earthquakes, and Zika. In coordinating planning and response efforts, I

have worked closely with nearly all programs in CDPH and have developed an understanding of not only their day-to-day activities but also how these activities must shift during emergencies.

6. CDPH aims to optimize the health and wellbeing of all people in California. CDPH works with local health departments, as well as public and private partners, to implement policies and programs that advance public health. Because California has a large, diverse population that covers a vast geographic area, CDPH's local health departments, public partners, and private partners are vital to informing, coordinating, and providing quality public health services to the public.

7. CDPH recently received notice, as set forth in detail below, that the following grants awarded to CDPH as a recipient or subrecipient had been terminated by the U.S. Department of Health and Human Services, Centers for Disease Control (CDC):

a. Immunization and Vaccines for Children Grant (Grant no. 6 NH23IP922612-05-09);
b. Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) Cooperative Agreement and its supplements Enhancing Detection (Grant no. 6 NU50CK000539-01-10) and Enhancing Detection Expansion (Grant no. 6 NU50CK000539-02-07);
c. CDC-RFA-OT21-2103 - National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Grant (Grant no. 6NH750T000035-01-07) (Health Disparities Grant).

8. The terminated awards as described in paragraph 7, as originally granted, included funding of over $2,000,000,000.

Immunization and Vaccines for Children Grant (CDC-RFA-IP19-1901)

9. In 2020, CDC invited applications for Immunization and Vaccines for Children grant supplemental funding.

10. While the initial bid for applications identified the purpose of the grant was to enhance the Vaccine for Children (VFC) program, which supports vaccinations against disease such as measles and influenza, and to implement forthcoming immunization against COVID-19, by 2023, CDC more clearly indicated the need to sustain and strengthen vaccine access for all ages and all types of diseases. Notably, in July 2023, CDC issued guidance that these funds "may integrate other Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as long as COVID-19 vaccine is included," recognizing the need for improved access and distribution of vaccines in general. A true and correct copy of this guidance, dated July 6, 2023, is attached as Exhibit A. Since 2020, CDPH has consistently been approved for an extension of this grant.

11. As set out in CDPH's annual grant proposals to CDC, CDPH intended to use the Immunization and Vaccines for Children grant to support routine and emergency immunization with a variety of vaccines for children and adults, including but not limited to, vaccines against COVID-19, measles, and influenza. As the COVID-19 pandemic disrupted routine immunization, the Immunization and Vaccines for Children grant seeks to sustain and strengthen vaccine access for all ages and all types of diseases.

12. The grant was initially approved on September 23, 2020, requiring expenditure of the funds by July 5, 2021. A true and correct copy of the corresponding Notice of Award and its attachments, dated September 23, 2020, is attached as Exhibit B. This provision has remained in place through the grant extensions.

13. Since 2020, CDC consistently extended the expenditure date and added funds to the grant. As of November 2024, this grant funding was set to expire June 30, 2025. In December 2024, CDPH was notified via GrantSolutions, CDC's grant administration online platform, that that it could apply for a No Cost Extension of funding through June 30, 2027. CDPH submitted its request for a no-cost extension on or about February 26, 2025. According to a true and correct copy of a GrantSolutions screenshot taken March 26, 2025, attached as Exhibit C, CDPH's request for a No Cost Extension had been "approved" CDPH relied on this approval of a No Cost Extension of the grant funding. Accordingly, CDPH has continued its approved grant activities since February 26, 2025.

14. On March 25, 2025, without any prior notice or indication, CDC informed CDPH that effective March 24, 2025, its Immunization and Vaccines for Children grant was being terminated. A true and correct copy of the grant award termination notice is attached as Exhibit D. As set forth therein, according to CDC, the termination was based on the end of the COVID-19 pandemic, even though the grants are not limited solely to activities related to COVID-19 and expressly authorize investments in public health systems and apparatus to prepare for *future* pandemics. No appeal rights or processes were included in this termination notice.

15. Since September 23, 2020, CDPH has used the Immunization and Vaccines for Children grant funds in a manner fully consistent with CDC's statements regarding the nature of the grant and CDC's grant application.

16. CDPH relies on this grant to operate and maintain its vaccine management system, which supports digital vaccine records, scheduling clinical vaccine appointments, and vaccine ordering, for COVID-19 as well as other vaccines, for all ages. Addressing deficiencies and delays that existed in pre-COVID-19 vaccine access and distribution, this system helps

support the rapid distribution of vaccines and supports critical routine vaccine programs, such as the Vaccines for Children (VFC) and Vaccines for Adults (VFA) programs; connects patients with tools and resources to receive vaccinations; and provides health care providers and local health departments with tools to effectively manage vaccination clinics. This system allows health care providers to enroll in these vaccine programs and order and track vaccines. It also allows CDPH to allocate, order, and distribute vaccines to health care providers and local health jurisdictions serving Medi-Cal patients.

17. CDPH relied and acted upon its expectation and understanding that CDC would fulfill its commitment to provide Immunization and Vaccines for Children funding it had awarded to CDPH. CDPH has relied on these federal funds to maintain the only system to order publicly funded vaccines for Californians. Without this system, any participants in the program would be unable to access important vaccines, including vaccines for measles, influenza, and COVID-19. To illustrate the scope of this impact, the Vaccines for Children (VFC) program impacts approximately 4.5 million children – roughly half of California's youth population – and supplies them with over 10 million vaccine doses a year.

18. In addition, CDPH relied on the grant to provide operational and maintenance support to a variety of systems of vaccination infrastructure, such as California's digital vaccine records, processing students' medical exemptions from vaccination, and clinic appointments. Approximately ten million Californians have relied on the system to obtain their digital vaccine records for school, work, and other settings. Without this federal funding, California's critical immunization infrastructure that supports vaccine-preventable disease control efforts and response to public health needs would be weakened.

19. Prior to the grant award termination on March 24, 2025, CDC had never provided CDPH with notice, written or otherwise, that the grant administered by CDPH was in any way unsatisfactory. In fact, the grant had been renewed and expanded at least four times.

Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) Cooperative Agreement Grant Supplements

20. On August 8, 2020, CDPH entered into a contract with Public Health Foundation Enterprises, Inc. dba Heluna Health (Heluna Health) authorizing Heluna Health to submit a grant application to CDC for funding opportunities under the Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Cooperative Agreement. A true and correct copy of the corresponding Agreement between CDPH and Heluna Health dated August 8, 2020, is attached as Exhibit E. CDPH and Heluna Health has continued to extend this contract through amendments. In September 2024, CDPH and Heluna Health executed a Bona Fide Agent Designation for purposes of ELC grant submission. A true and correct copy of the corresponding Bona Fide Agent Designation between CDPH and Heluna Health dated September 5, 2024, is attached as Exhibit F. As such, Heluna Health is the bona fide fiscal agent for the funds and CDPH is a subrecipient of the ELC funding.

21. In 2020, CDC invited applications for Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) Enhancing Detection. In 2021, CDC invited applications for ELC Enhancing Detection Expansion, which intended to build on the prior work supported under ELC Enhancing Detection. These grants build on the ELC Cooperative Agreement and have enhanced the capacity of each recipient jurisdiction's public health capacity to cohesively and comprehensively address infectious disease needs. On or about January 31, 2024, CDC clarified there was a no-cost extension for the Enhancing Detection and

Enhancing Detection Expansion supplements through July 31, 2026. A true and correct copy of this guidance is attached, dated January 31, 2024, is attached as Exhibit G.

22. These grants were to support the public health response to COVID-19 and lay the foundation for the future of public health surveillance. CDC had indicated that the funds were allowed for public health activities to prevent or mitigate impacts of communicable diseases including, but not limited to, COVID-19. CDC's June 2020 guidance on the ELC Enhancing Detection supplement stated that the funds will not only support COVID-19 response, but "lay the foundation for the future of public health surveillance." A true and correct copy of this guidance is attached, is attached as Exhibit H. This broader use was further clarified in the CDC's January 31, 2024, guidance (Exhibit G), which identified that the funds may be used to integrate other pathogens and syndromes as long as COVID-19 testing and surveillance is included. Costs related to maintenance and operations or licensing of integrated disease surveillance systems can be used for COVID-19 and other pathogens, and includes training on these systems.

23. As set out in its grant proposal, CDPH intended to use the ELC supplemental grants to correct shortfalls identified during the pandemic response. These included addressing improvements in workforce development, software systems related to outbreak management, disease reporting, laboratory reporting, and upgrades and improvements to infrastructure including replacement of laboratory equipment, which lays the foundation for the future of public health monitoring and improves preparedness for any future public health issues.

24. On May 18, 2020, CDC produced a Notice of Award setting forth the terms and conditions of the grant award for the ELC Enhancing Detection supplement to Heluna Health.

Heluna Health provided CDPH a copy of this Notice of Award. A true and correct copy of the corresponding Notice of Award and its attachments, dated May 18, 2020, is attached as Exhibit I.

25. Since May 18, 2020, CDPH has used the ELC Enhancing Detection supplement grant funds in a manner fully consistent with CDC's statements regarding the nature of the grant and CDPH's grant application.

26. On January 13, 2021, CDC produced a Notice of Award setting forth the terms and conditions of the grant award for the ELC Enhancing Detection Expansion supplement to Heluna Health. Heluna Health provided CDPH a copy of this Notice of Award. A true and correct copy of the corresponding Notice of Award and its attachments, dated January 13, 2021, is attached as Exhibit J.

27. Since January 13, 2021, CDPH has used the ELC Enhancing Detection and ELC Enhancing Detection Expansion supplement grant funds in a manner fully consistent with CDC's statements regarding the nature of the grant and CDPH's grant applications.

28. CDPH relied on the ELC supplement funds to support the software and systems to monitor, investigate and appropriately and timely respond to infectious disease outbreaks, known as CalCONNECT. CalCONNECT helps improve timely and efficient management of complex cases, contact investigations, and outbreaks, improve response time for investigation, contact tracing, monitoring, and public health communications. CalCONNECT has allowed for automation that supports the state and local health jurisdictions to collect and share infectious disease data faster, identify and prioritize the most vulnerable populations to provide more timely public health interventions (e.g., medicines to prevent a second case), and improve accuracy. This information is used for disease investigation activities at the state and local level for infectious disease including Tuberculosis, Mpox, and HIV, and to monitor cases of novel

infections including Avian flu, Ebola, and Marburg. It also provides a secure way for local health jurisdictions to track individuals who require follow up and check-ins to prevent the spread of disease. Without these federal funds, the modernized systems face risks including degradation, resulting in delays in reporting and identification of outbreaks and care, which could exacerbate the spread of disease and puts at risk California's preparedness for future pandemics.

29. Another software system critical for communicable disease prevention is the Future Disease Surveillance System (FDSS). Without ELC funding, CDPH's ability to develop the FDSS, which is a critical replacement to the current legacy California Reportable Disease Information Exchange (CalREDIE), is uncertain. CalREDIE is an electronic disease reporting system to allow local health jurisdictions to submit disease case reports to CDPH. During the COVID pandemic, CalREDIE was severely strained by the volume of reports being submitted as well as being inflexible to changing reporting requirements, in addition to a problematic inability to share data with other systems. The outdated CalREDIE system underwent maximum feasible patched updates during the pandemic and does not include two of our largest local health jurisdictions with more than 25% of our population; however, it became clear that a comprehensive replacement was essential.

30. FDSS is intended to replace CalREDIE and allow for submission of data from all local health jurisdictions in California. It would be able to import and export data to CalCONNECT and other systems and would be the foundation for all reportable diseases to allow for more effective and efficient reporting and analysis. The impact would be more timely recognition and response to disease trends including to outbreaks and pandemics.

31. Additionally, CDPH relies on the grant funds to provide continued training and subject matter expertise in areas such as epidemiology and infectious disease to ensure health

providers are sufficiently up to date on preventing spread of communicable diseases including, but not limited to, COVID-19, Tuberculosis, Mpox, HIV, Avian flu, Ebola, and Marburg. Without funds for this training, California risks gaps in knowledge on preventing the spread of disease.

32. On or about March 25, 2025, representatives of Heluna Health informed CDPH that they plan to issue a stop work order on March 27, 2025, which would require CDPH and the local health jurisdictions to halt activities or find alternate funding for state and local staff and contracts. CDPH received the stop order on March 28, 2025. Heluna Health provided CDPH with a copy of the CDC grant award termination notices that Heluna Health had received. In the first notice the CDC purported to end the grant period for all ELC grant supplements, but the CDC's second notice stated that only five ELC related grants were terminated, including the ELC Enhancing Detection and ELC Enhancing Detection Expansion. A true and correct copy of the grant award terminations are attached as Exhibit K. As set forth therein, according to CDC, the termination was based on the end of the COVID-19 pandemic, even though the grants are not limited solely to activities related to COVID-19 and expressly authorize investments in public health systems and apparatus to prepare for *future* pandemics. No appeal rights or processes were included in this termination notice.

33. It is not possible to extrapolate the COVID-specific aspects of these grants. The COVID pandemic brought awareness to a broad need to improve our state's response to a pandemic and ability to track and monitor infectious diseases. The funds have helped to modernize CDPH's ability to monitor and collect data on a multitude of threats in real time, to help respond to communicable disease outbreaks, and to prevent the further spread of disease

including, but not limited to, COVID-19, Ebola, Marburg, and Avian Influenza. The loss of funds will have a major impact on CDPH's ability to protect public health.

Further ELC Grant Termination Impacts to California

34. The Notice of Award terminating the supplement grants for which CDPH is a subrecipient also showed three other supplement ELC grants were being terminated by CDC effective on or about March 25, 2025, including Coronavirus Aid, Relief, and Economic Security Act (CARES); Strengthening Healthcare Associated Infections/Anti-Microbial Resistance (HAI/AR) Program Capacity 2 (SHARP 2+); and Infection Prevention Control (IPC).

35. While CDPH may not receive direct federal funding for the ELC IPC, CARES or SHARP2+ supplemental grants, CDPH and local health departments rely on the funds and the public health benefits from funded services. Prior to the pandemic, the public health infrastructure had not been enhanced or modernized to be equipped to handle public health emergencies and large outbreaks of disease.

36. These supplemental grants are used to support California's strengthening of public health resources. In particular, the ELC SHARP 2+ funds were intended to contract with a CDC-identified vendor to develop a database to collect real-time data on available hospital beds. Having such information will assist hospitals in directing injured and ill patients to available health facilities during all types of emergencies, where efficient routing saves lives. In response to this opportunity, California enacted Chapter 999, Statutes of 2024 (A.B. 177), to require health facilities to report real-time hospital bed availability data via the proposed database that the identified vendor has developed for such purpose. The termination of this federal funding jeopardizes a centralized database, which risks slowing access to care in emergencies.

37. CDPH regulates and licenses nursing facilities and also manages the HAI (healthcare acquired infections) program. IPC funds help CDPH train staff from California nursing facilities in infection prevention control against all communicable diseases such as COVID-19, Tuberculosis, norovirus, and the many communicable diseases common in nursing home facilities.

38. CARES funds have been used to increase qualified staffing to build public health infrastructures, especially among those local health departments that are rurally isolated and do not have a large staff pool from which to hire. CARES allowed for the staffing and training of professionals such as epidemiologists, microbiologists, laboratory staff, disease investigators and surveillance staff, and administrators in local health departments.

Health Disparities Grant

39. In 2021, CDC invited applications for National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities (Health Disparities grant).

40. The Health Disparities grant was for the purpose of improving testing capabilities and other COVID-19 response activities in populations that are at high-risk and underserved, including racial and ethnic minority groups and people living in rural communities, including developing or identifying best practices for states and public health officials to use for contact tracing. The Health Disparities grant was also intended to address COVID-19 related health disparities and advance health equity (e.g., through strategies, interventions, and services that consider systemic barriers and potentially discriminatory practices that have put certain groups at higher risk for diseases like COVID-19) in racial and ethnic minority groups and rural populations within state, local, US territorial, and freely associated state health jurisdictions. As

described in the notice of funding opportunity, "[a]ll strategies should aim to build infrastructures that both address disparities in the current COVID-19 pandemic and set the foundation to address future response." A true and correct copy of the notice of funding opportunity, dated May 3, 2021 are attached as Exhibit L.

41. CDC approved CDPH's Health Disparities grant on May 26, 2021, for the term of June 1, 2021, to June 1, 2023. On September 9, 2022, CDC awarded a no-cost extension to May 31, 2024. On April 12, 2024, CDC awarded a second and final no-cost extension until May 31, 2026

42. On May 26, 2021, CDC produced a Notice of Award setting forth the terms and conditions of the grant award. A true and correct copy of the corresponding Notice of Award and its attachments, dated May 26, 2021, is attached as Exhibit M.

43. Since June 2021, CDPH has used the Health Disparities grant funds in a manner fully consistent with CDC's statements regarding the nature of the grant and CDPH's grant application.

44. CDPH relied on the funds to strengthen public health infrastructure with an equity lens, preparedness, and response capabilities and services. Forty-seven local health jurisdictions— that already work closely with and understand how to most efficiently and effectively reach underserved, high risk, and disproportionally affected demographics—have used the grant funds for developing health equity plans and to design and implement plans for data collection and reporting. Local health jurisdictions have also provided mental health services to youth, families, and schools; provided culturally and linguistically accessible health services; provided health information and data to community members; provided emergency

preparedness supplies to community members; and hired equity staff and program staff at the local health jurisdictions.

45. CDPH has complied with the requirements of the grant, and the grant was extended twice to complete all project activities. To the best of my knowledge, local health jurisdictions and community-based organizations have also complied with the requirements of the grant.

46. On March 25, 2025, without any prior notice or indication, CDPH was informed that the Health Disparities grant was being terminated as of March 24, 2025. A true and correct copy of the grant award termination notice is attached as Exhibit N. As set forth therein, according to CDC, the termination was based on the end of the COVID-19 pandemic. No appeal rights or processes were included in this termination notice.

47. Without the funds, the final reports and health improvement plans, and data collection plans from local health jurisdictions will not be completed, preventing CDPH from learning how to better and more efficiently respond to specific communities in future public health crises, which could exacerbate health disparities. Additionally, as many of these communities impacted by health disparities and inequalities already face distrust in public health and public health jurisdictions due to health disparities and inequalities, failure to complete this work may erode these communities' public trust of local health jurisdictions and CDPH and, exacerbate gaps already identified during the COVID-19 pandemic.

48. All told, there is approximately $800 million remaining on the Immunization and Vaccines for Children grant; ELC Expansion, Enhancement Detection, CARES, IPC, and SHARP 2+ grant supplements and Health Disparities grants, with roughly $500 million obligated to the state and roughly $300 million obligated to the local health departments. California relied

upon the CDC's commitments and is mid-stream on numerous critical projects for the modernization and improvement of California's pandemic response infrastructure based on the expectation that CDC would fulfill those commitments. As CDC indicated in its previous guidance, the need for these funds extends beyond the COVID-19 pandemic. Recently, California has used the grant supported programs to coordinate with local health jurisdictions and monitor and respond the avian flu and CDPH's vaccination and schedule systems are used to find and schedule vaccine appointments for the seasonal flu (which may reduce the chance of human and avian flu viruses mixing and becoming more dangerous) and avian flu testing.

49. The CDC's abrupt termination causes irreparable harm by ceasing critical projects mid-stream, throwing those efforts into doubt and creating a serious risk that the resources expended thus far will go to waste without accomplishing their intended goals. Rather than taking the lessons from COVID-19 and putting them into action, the unexpected termination leaves California unprepared for future pandemics and risks exacerbating the spread of otherwise preventable disease.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed on March 29, 2025, in Sacramento, California.

By: Susan Fanelli

Susan Fanelli
Chief Deputy Director of Health Quality and Emergency Response
California Department of Public Health

Exhibit A

Updated Clarity and Guidance Related to your IP19-1901 COVID-19 Funding

Clarification of Allowable Activities for the COVID 3* and COVID 4* Supplements

- As the COVID-19 vaccine becomes more integrated into the routine immunization schedule, COVID-19 funded activities should still focus on directly benefiting COVID vaccine coverage and uptake. Activities can be conducted and integrated within **broader immunization program activities.** Examples of broad-scale immunization work directly benefiting COVID vaccine coverage that can be COVID-19-funded include (not exhaustive):
    - **Vaccine confidence** activities
    - **Vaccine equity activities**
    - General **provider or patient education**
    - **IIS enhancements and data modernization**

- COVID-19-funded infrastructure and activities may integrate other ACIP-recommended vaccines **as long as COVID-19 vaccine is included in the effort**. Examples include (not exhaustive):
    - COVID-funded **personnel** may also conduct activities to raise awareness and coverage of other VPDs, as long as COVID-19 awareness and coverage continues to be included in the effort
    - COVID-funded personnel that conduct COVID **site visits** may also conduct provider site visits for adult and VFC providers, as needed, as long as they continue to also conduct COVID site visits
    - COVID-funded **contracts** may include other ACIP-recommended vaccination activities, as long as COVID-19 vaccine work remains a central part of the activities. Recipients should consult with their IOSB Project Officer, and their jurisdiction acquisition office as necessary, prior to establishing new contracts or making changes to existing contracts.
    - COVID-related **vaccination activities** (e.g., personnel, mobile clinics, etc.) may also add other vaccines to their work

- Regarding flexibilities related to contractual activities, consult with your jurisdiction acquisition office to learn more about your jurisdiction-specific policies. This will also require negotiation with the intended vendor.
    - Service agreements, also sometimes called a maintenance agreement/contract, are a unique type of contract that is frequently paid up-front and covers a specified timeframe. Service agreements function like warranties, in that they are paid up front, cover a specified period of time in the future, and should they be needed, no additional costs occur. Service agreements that are paid up-front and have no additional costs associated at a later date can have timeframes that exceed the Immunization and Vaccines for Children cooperative agreement period of performance which is currently June 30, 2024.

- **Suggested List of Specific Activities, As Needed, for Use of Remaining COVID Funding**
- Continue active COVID-19 vaccine distribution, administration, and oversight
- COVID-19 inventory reconciliation exercise
- Purchase of storage & handling supplies and, including DDLs, for providers.
- Funding IIS enhancements related to vaccine ordering, inventory management, and recording waste
- Communication of COVID-19 vaccine recommendation changes in preparation for Fall 2023
- Partner retention and integration, including continuing partnerships with pharmacies
- Maintaining awareness of vaccine coverage in LTCF/SNF

- Strengthening VPD coverage in Health Care Settings including HCW, Dialysis, LTCF
- Development of a COVID After-Action-Report
- Enhancement of COVID surveillance activities and reporting

Three Activities No Longer Allowable

- New **incentive requests**, new requests to **purchase vehicles,** and new requests for **construction** are no longer allowable. This applies to direct awardees and subrecipients (e.g., LHDs). The allowance of these purchases was uniquely given during the pandemic, but they are not allowed under routine operations
- **Leasing vehicles remains an allowable** use of IP19-1901 funds
- All incentive, vehicle, and construction approvals already received **remain effective and allowable until the funds are expended**

***COVID3 and COVID4 Supplements as described here:**

- COVID-19 Vaccination Supplemental Funding (cdc.gov)
- COVID-19 Vaccination Supplement 4 April 2021 (cdc.gov)

Exhibit B

1. DATE ISSUED *MM/DD/YYYY*: 09/23/2020

1a. SUPERSEDES AWARD NOTICE dated 06/21/2020 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

2. CFDA NO.
[redacted] - Immunization Cooperative Agreements

3. ASSISTANCE TYPE Cooperative Agreement

4. GRANT NO. [redacted]
Formerly

5. TYPE OF AWARD
Demonstration

4a. FAIN [redacted]

5a. ACTION TYPE Post Award Amendment

6. PROJECT PERIOD *MM/DD/YYYY*
From 07/01/2019 Through 06/30/2024

7. BUDGET PERIOD *MM/DD/YYYY*
From 07/01/2020 Through 06/30/2021

8. TITLE OF PROJECT (OR PROGRAM)
CDC-RFA-IP19-1901 Immunization and Vaccines for Children

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
CDC Office of Financial Resources

[redacted]

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)
Sections 317, 317(k)(2) of the Public Health Service Act (42 U.S.C. Sections 247b. 247b(k)(2) and 247c). as amended.

9a. GRANTEE NAME AND ADDRESS
Public Health, California Department of
[redacted]

9b. GRANTEE PROJECT DIRECTOR
[redacted]

10a. GRANTEE AUTHORIZING OFFICIAL
[redacted]

10b. FEDERAL PROJECT OFFICER
[redacted]

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes Direct Assistance)

I Financial Assistance from the Federal Awarding Agency Only
II Total project costs including grant funds and all other financial participation — I

a.	Salaries and Wages	1,937,182.00
b.	Fringe Benefits	1,017,876.00
c.	Total Personnel Costs	2,955,058.00
d.	Equipment	0.00
e.	Supplies	1,069,849.00
f.	Travel	84,245.00
g.	Construction	0.00
h.	Other	4,300,241.00
i.	Contractual	58,246,087.00
j.	TOTAL DIRECT COSTS	66,655,480.00
k.	INDIRECT COSTS	585,127.00
l.	TOTAL APPROVED BUDGET	67,240,607.00
m.	Federal Share	67,240,607.00
n.	Non-Federal Share	0.00

12. AWARD COMPUTATION

a. Amount of Federal Financial Assistance (from item 11m)	67,240,607.00
b. Less Unobligated Balance From Prior Budget Periods	596,980.00
c. Less Cumulative Prior Award(s) This Budget Period	37,318,999.00
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	29,324,628.00
13. Total Federal Funds Awarded to Date for Project Period	123,592,306.00

14. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 3		d. 6	
b. 4		e. 7	
c. 5		f. 8	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES: **b**
a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER *(See REMARKS)*

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARDING AGENCY ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation
b. The grant program regulations.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - ☒ Yes ☐ No)
Supplemental Funding: Financial Assistance in the amount of $29,324,628

GRANTS MANAGEMENT OFFICIAL:
[redacted]

17.OBJ CLASS 41.51	18a. VENDOR CODE 1743204993A1	18b. EIN 743204993	19. DUNS 799150615	20. CONG. DIST. 06
FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	APPROPRIATION
21. a. [redacted]	b. [redacted]	c. IP	d. $643,096.00	e. [redacted]
22. a. [redacted]	b. [redacted]	c. IP	d. $28,681,532.00	e. [redacted]
23. a.	b.	c.	d.	e.

NOTICE OF AWARD (Continuation Sheet)

PAGE 2 of 3	DATE ISSUED 09/23/2020
GRANT NO. [redacted]	

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

NOTICE OF AWARD (Continuation Sheet)

PAGE 3 of 3	DATE ISSUED 09/23/2020
GRANT NO. [redacted]	

Federal Financial Report Cycle			
Reporting Period Start Date	Reporting Period End Date	Reporting Type	Reporting Period Due Date
07/01/2019	06/30/2020	Annual	09/28/2020
07/01/2020	06/30/2021	Annual	09/28/2021

AWARD ATTACHMENTS

California Department of Public Health [redacted]

1. Terms and Conditions

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Non-research awards at https://www.cdc.gov/grants/federalregulationspolicies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number IP19-1901, entitled, *Immunization and Vaccines for Children*, which are hereby made a part of this Non-research award, hereinafter referred to as the Notice of Award (NoA).

Supplemental Component Funding: Additional funding in the amount **$29,324,628** is approved for the Year 02 budget period, which is July1, 2020 through June 30, 2021.

The NOFO provides for the funding of multiple components under this award. The approved component funding levels for this notice of award are:

NOFO Component	Amount
CORE	$643,096
COVID-19 CARES	$28,681,532

Recipients have until July 5, 2021 to expend all COVID-19 funds awarded herein

Overtime: Because overtime costs are a very likely and reasonable expense during the response to COVID-19, CDC will allow recipients to include projected overtime in their budgets. Recipients should be careful to estimate costs based on current real-time needs and will still be required to follow federal rules and regulations in accounting for the employees' time and effort.

Coronavirus Disease 2019 (COVID-19) Funds: A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the "CARES Act") (P.L. 116-136); and/or the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) agrees, as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health measures (e.g., social distancing, home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation.

In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS– CoV–2 or to diagnose a possible case of COVID–19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC. HHS laboratory reporting guidance is posted at: https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-

reporting-guidance.pdf.

Further, consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the purpose of this award, and the underlying funding, the recipient is expected to provide to CDC copies of and/or access to COVID-19 data collected with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.

This award is contingent upon agreement by the recipient to comply with existing and future guidance from the HHS Secretary regarding control of the spread of COVID-19. In addition, recipient is expected to flow down these terms to any subaward, to the extent applicable to activities set out in such subaward.

Unallowable Costs:

- Research
- Clinical care
- Publicity and propaganda (lobbying):
    - Other than for normal and recognized executive-legislative relationships, no funds may be used for:
        - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
        - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
    - See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients: https://www.cdc.gov/grants/documents/Anti-Lobbying_Restrictions_for_CDC_Grantees_July_2012.pdf

- All unallowable costs cited in CDC-RFA-CK19-1904 remain in effect, unless specifically amended in this guidance, in accordance with 45 CFR Part 75 – Uniform Administrative Requirements, Cost Principles, And Audit Requirements for HHS Awards.

COVID-19 and VFC Funding Budget Revision Requirement: The recipient must submit a revised budget with a narrative justification and workplan within 30 days after the receipt of this Notice of Award. Failure to submit the required information in a timely manner may adversely affect the future funding of this project. If the information cannot be provided by the due date, you are required to contact the GMS/GMO identified in the CDC Staff Contacts section of this notice before the due date. **A separate narrative and workplan must be submitted in accordance with the COVID-19 guidance and must also be uploaded in GMM as an amendment with a SF424A.**

REPORTING REQUIREMENTS

Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the following addresses:

CDC, Office of Grants Services
[redacted]
[redacted]@cdc.gov (Include "Mandatory Grant Disclosures" in subject line)

AND

U.S. Department of Health and Human Services
[redacted]
(Include "Mandatory Grant Disclosures" in subject line)
or Email: MandatoryGranteeDisclosures@oig.hhs.gov

Recipients must include this mandatory disclosure requirement in all subawards and contracts under this award.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

CDC is required to report any termination of a federal award prior to the end of the period of performance due to material failure to comply with the terms and conditions of this award in the OMB-designated integrity and performance system accessible through SAM (currently FAPIIS). (45 CFR 75.372(b)) CDC must also notify the recipient if the federal award is terminated for failure to comply with the federal statutes, regulations, or terms and conditions of the federal award. (45 CFR 75.373(b))

PAYMENT INFORMATION

The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1- 800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, [redacted]. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application.

The grant document number identified on the bottom of Page 1 of the Notice of Award must be known in order to draw down funds.

Component: CORE
Document Number: [redacted]

Component: COVID-19
Document Number: [redacted]

CDC Staff Contacts

Grants Management Specialist:

[redacted]@cdc.gov

Stewardship: The recipient must exercise proper stewardship over Federal funds by ensuring that all costs charged to your cooperative agreement are allowable, allocable, and reasonable and that they address the highest priority needs as they relate to this program.

All the other terms and conditions issued with the original award remain in effect throughout the budget period unless otherwise changed, in writing, by the Grants Management Officer.

Exhibit C

GrantSolutions Amendment Application Control Checklist

Post Award Action: No Cost Extension

(Amendment) Approved (Processing) (Read Only)

This is your GrantSolutions Application Control Checklist (EACC). You will use the EACC to track the status of your application.

To complete your application electronically, enter information by using the online forms and/or adding attachments (upload/mail-in). Required items are noted by the exclamation point image. If an enclosure has not been verified, a red 'X' image is displayed.

Please verify that all documents submitted with the application package appear as expected in the Original Submission PDF. Not all file types may accurately print to PDF.

Print Application:

Original Submission

Please verify that all documents submitted with the application package appear as expected in the Original Submission PDF. Not all file types may accurately print to PDF.

Applicant	California Department of Public Health
Grant Number	[redacted]
Application Number	
Action	No Cost Extension
Project Title	[redacted] Immunization and Vaccines for Children
Submitted Date	02/26/2025 10:36 AM Eastern Time

Online Forms	Enclosure(s)	Attachment(s)	Status
SF-424A Budget Information - Non-Construction	View Online Print Completed	1 Uploaded Files 0 Mail-in Items	✓
Project Period Revision	View Online	0 Uploaded Files 0 Mail-in Items	✓
Project Abstract Summary (Version 2.0)	View Online Print Completed	1 Uploaded Files 0 Mail-in Items	✓
SF-424 Application for Federal Assistance (Version 4.0)	View Online	1 Uploaded Files	✓

Exhibit D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 03/24/2025

Recipient Information

1. Recipient Name
Public Health, California Department of
[redacted]
-5015
(916) 552-8264

2. Congressional District of Recipient
06

3. Payment System Identifier (ID)
[redacted]

4. Employer Identification Number (EIN)
[redacted]

5. Data Universal Numbering System (DUNS)
[redacted]

6. Recipient's Unique Entity Identifier (UEI)
[redacted]

7. Project Director or Principal Investigator
[redacted]

8. Authorized Official
[redacted]

Federal Agency Information

CDC Office of Financial Resources

9. Awarding Agency Contact Information
[redacted]

10. Program Official Contact Information
[redacted]

Federal Award Information

11. Award Number
[redacted]

12. Unique Federal Award Identification Number (FAIN)
[redacted]

13. Statutory Authority
Sections 317, 317(k)(2) of the Public Health Service Act (42 U.S.C. Sections 247b, 247b(k)(2) and 247c), as amended.

14. Federal Award Project Title
CDC-RFA-IP19-1901 Immunization and Vaccines for Children

15. Assistance Listing Number
93.268

16. Assistance Listing Program Title
Immunization Cooperative Agreements

17. Award Action Type
Administrative Action

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 07/01/2023 **- End Date** 03/24/2025	
20.	**Total Amount of Federal Funds Obligated by this Action**	$0.00
	20a. Direct Cost Amount	$0.00
	20b. Indirect Cost Amount	$0.00
21.	Authorized Carryover	$136,482,498.00
22.	Offset	$16,835,552.00
23.	Total Amount of Federal Funds Obligated this budget period	$115,241,040.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$115,241,040.00
26.	**Period of Performance Start Date** 07/01/2019 **- End Date** 03/24/2025	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$1,088,470,084.00

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
[redacted]

30. Remarks

Department Authority

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 03/24/2025

Recipient Information

Recipient Name
Public Health, California Department of
[redacted]

Congressional District of Recipient
06

Payment Account Number and Type
[redacted]

Employer Identification Number (EIN) Data
[redacted]

Universal Numbering System (DUNS)
[redacted]

Recipient's Unique Entity Identifier (UEI)
[redacted]

31. Assistance Type
Cooperative Agreement

32. Type of Award
Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$4,693,524.00
b. Fringe Benefits	$2,441,942.00
c. Total Personnel Costs	$7,135,466.00
d. Equipment	$0.00
e. Supplies	$4,387,714.00
f. Travel	$122,391.00
g. Construction	$0.00
h. Other	$17,213,077.00
i. Contractual	$238,913,930.00
j. TOTAL DIRECT COSTS	$267,772,578.00
k. INDIRECT COSTS	$786,512.00
l. TOTAL APPROVED BUDGET	$268,559,090.00
m. Federal Share	$268,559,090.00
n. Non-Federal Share	$0.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	ASSISTANCE LISTING	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
[redacted]	[redacted]	IP	41.51	93.268	$0.00	[redacted]
[redacted]	[redacted]	IP	41.51	93.268	$0.00	[redacted]
[redacted]	[redacted]	IP	41.51	93.268	$0.00	[redacted]
[redacted]	[redacted]	IP	41.51	93.268	$0.00	[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 03/24/2025

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

AWARD ATTACHMENTS

Public Health, California Department of [redacted]

1. Terms & Conditions - Termination

TERMS AND CONDITIONS OF AWARD

Termination: The purpose of this amendment is to terminate the use of any remaining COVID-19 funding associated with this award. The termination of this funding is for cause. HHS regulations permit termination if "the non-Federal entity fails to comply with the terms and conditions of the award", or separately, "for cause." The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: To ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out. Termination of use of funding under the listed document number(s) is effective as of the date set out in your Notice of Award.

Impacted document numbers are included on page 2 of this Notice of Award (NoA).

No additional activities can be conducted, and no additional costs may be incurred, as it relates to these funds. Unobligated award balances of COVID-19 funding will be de-obligated by CDC. Award activities under other funding may continue consistent with the terms and conditions of the award.

Final Federal Financial Report (FFR, SF-425): Within 30 days please submit Final FFRs for impacted document numbers. The FFR should only include those funds authorized and expended during the timeframe covered by the report. The final report must indicate the exact balance of unobligated funds and may not reflect any unliquidated obligations. Should the amount not match with the final expenditures reported to the Payment Management System (PMS), you will be required to update your reports to PMS accordingly.

All other terms and conditions of this award remain in effect.

Exhibit E

Heluna Health
EMPOWERING POPULATION HEALTH INITIATIVES SINCE 1969

[redacted] | www.helunahealth.org

AGREEMENT BETWEEN

HELUNA HEALTH

AND

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
THE STATE

This Agreement is made and entered into as of _____ by and between PUBLIC HEALTH FOUNDATION ENTERPRISES, INC., DBA Heluna Health, a 501(c)(3) California nonprofit corporation (hereinafter referred to as "HELUNA HEALTH"), and the Party identified in Section 1 below (hereinafter be referred to as "the State".

RECITALS

A. The State designated Heluna Health, as its bona fide agent to submit a grant application under the State of California's eligibility in lieu of a state application for the federal Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC) funding opportunity: Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Cooperative Agreement. The designation is in effect from August 1, 2017 through July 31, 2022, or until the ELC Cooperative Agreement terminates, whichever date is earlier.

B. HELUNA HEALTH has been granted an award by Department of Health and Human Services-Centers for Disease Control and Prevention (the "Funding Agency"); under contract number [redacted] Federal Award Identification Number (FAIN) [redacted] and Catalog of Federal Domestic Assistance (CFDA) number [redacted] under which HELUNA HEALTH and its subcontractors and subawardees will collaborate on the program.

C. The State has expertise in the necessary area(s) which their expertise can assist HELUNA HEALTH to perform its obligations under the Funding Award Agreement; and

D. HELUNA HEALTH desires to engage the services of the State to assist HELUNA HEALTH in the performance of certain of its obligations under the Funding Award Agreement as set forth herein.

AGREEMENT

1. IDENTITIES OF PARTIES

THE STATE:

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

Address:
City/State/Zip:
Business Telephone: [redacted]

Name of Principal Investigator/Project Coordinator:

[redacted]
California Department of Public Health
Phone Number of Principal Investigator/ [redacted]

Is The State required to file a Single Audit with the Federal Government? (Required for Parties who receive Federal funds in the aggregate amount of $500,000 or more):
[X] Yes [ ] No

If yes, has The State filed the required Single Audit? [X] Yes [ ] No
(If yes, submit copy to HELUNA HEALTH prior to signing this Agreement)

HELUNA HEALTH:

Heluna Health
Address and Phone #: [redacted]

Program Name: ELC Enhancing Detection Program
Program/CID #: [redacted] (One per agreement)
Project Director Name: [redacted]
Project Director Phone #: [redacted]
Project Director Email Address: [redacted]@HelunaHealth.org
Contracts Manager Name: [redacted]
Contracts Manager Email Address: [redacted]

2. SCOPE OF SERVICES

(a) Services. The State shall perform the services, duties and obligations set forth in the Statement of Work ("SOW") attached as Exhibit A hereto, which is made a part hereof and incorporated herein by reference (the "Services"). The State shall perform the Services in accordance with the specifications, timetables and requirements set forth in this Agreement.

(b) Location(s) of Services. The State shall perform the Services at the following location(s): Throughout the State of California.

(c) State Principal Investigator/Project Coordinator. The State shall appoint the Principal Investigator/Project Coordinator (the "PI") identified above to be primary point of contact with HELUNA HEALTH with respect to the Services and to have primary responsibility within the State's organization for the performance of the (technical or programmatic) aspects of the Services. The State shall not replace or reassign the PI without HELUNA HEALTH's prior written approval.

(d) HELUNA HEALTH Project Director. The HELUNA HEALTH Project Director identified above shall be primarily responsible on behalf of HELUNA HEALTH for the overall direction of the Services, including review and approval of the State's performance of the Services. HELUNA HEALTH will notify the State if HELUNA HEALTH replaces or reassigns such Project Director.

(e) Performance Reporting. If requested by HELUNA HEALTH or CDC, the State shall submit a final technical or performance report, annual performance report, and quarterly performance reports. The final report shall be due 30 days after expiration or termination of this Agreement; annual reports and quarterly reports shall be due 30 days after the federal fiscal year reporting period. The State shall also provide any other reports as may be requested by HELUNA HEALTH. Performance reports shall include a comparison of actual accomplishments with goals and objectives in SOW established for the period, findings of the PI, or both, as requested by HELUNA HEALTH. Where possible, quantitative output data should be related to cost data for computation of unit costs. Other pertinent information will include, when appropriate, the reasons why established goals were not met and an analysis. The State shall immediately notify HELUNA HEALTH of developments that have a significant impact on the performance of the Services hereunder and of any problems, delays, or adverse conditions that materially impair its ability to meet the objectives of the Services, including providing a statement of the action taken or contemplated and any assistance needed to resolve the situation.

3. COMPLIANCE WITH FUNDING AWARD AGREEMENT AND LAWS AND REGULATIONS; FLOW DOWN PROVISIONS

(a) Compliance with Funding Contract. The State shall comply with, and shall ensure that all of its personnel and lower-tier subcontractors comply with, all of the rules, requirements and restrictions set forth in the Funding Award Agreement that are applicable to the State and its subcontractors' activities.

(b) Flow Down Provisions. Without limiting the generality of Section 3(a) above, the State shall comply with, and shall ensure that all of its personnel and lower-tier subcontractors comply with, all of the flow-down provisions of the Funding Award Agreement applicable to the State set forth in Exhibit C attached hereto or otherwise made available to the State (including through links to website pages), which are made a part hereof and incorporated herein by reference (the "Flow Down Provisions"). The State represents that it has carefully reviewed all of the Flow Down Provisions and is able to comply with all of the Flow Down Provisions. In the event that the requirements set forth in the Flow Down Provisions are greater than the requirements set forth in this Agreement, or in the event of any conflict between the provisions of this Agreement and the Flow Down Provisions, the Flow Down Provisions shall control and the State shall comply with the requirements set forth in the Flow Down Provisions in accordance with Section 2(a).

(c) Laws and Regulations. The State shall comply with all applicable state and federal statutes and regulations, in performing its obligations under this Agreement. Without limiting the generality of the foregoing, the State shall:

i. unless exempt, comply with the requirements under 2 CFR § 200, its subsequent histories and the Public Health Service Grants Policy Statement;

ii. unless exempt, comply with Executive Order 11246 entitled "Equal Employment Opportunity" as amended by Executive Order 11375 and as supplemented in Dept. of Labor regulations (41 CFR Part 60);

iii. comply with (and not violate) all statutes, laws, rules and regulations relating to non- discrimination against any employees or applicants for employment, including, without limitation, Title VII of the Civil Rights Act of 1964, The Americans with Disabilities Act Amendments Act of 2008, and the California Fair Employment and Housing Act, and shall take affirmative action to ensure that all employment related decisions are made in conformance with all such statutes, laws, rules and regulations; and

iv. unless it is exempt from doing so, comply with 45 CFR Part 76, Appendix B-Certification Regarding Debarment, Suspension, and Ineligibility, Voluntary Exclusion-Lower Tier Covered Transactions.

(e) Lower-tier Subcontractors/Subawardees. The State shall incorporate all of the terms and conditions of this Agreement into all lower-tier subcontracts that the State may enter into in connection with this Agreement, and shall ensure that all such lower-tier subcontractors

and their personnel comply with all of the requirements of this Agreement applicable to the State, and all of the rules, requirements and restrictions set forth in the Funding Award Agreement, including the Flow Down Provisions, that are applicable to such lower-tier subcontractors' activities.

4. PAYMENT FOR SERVICES

(a) Budget. The total compensation and reimbursements payable to the State hereunder shall be as set forth in the detailed budget for the Services attached hereto as Exhibit B (the "Budget"), which is made a part hereof and incorporated herein by reference, which Budget is as set forth in the Funding Award Agreement. The maximum amount payable to the State hereunder shall not exceed the maximum amount set forth in the Budget. If, at any time, HELUNA HEALTH determines that federal funds are insufficient to sustain existing or anticipated spending levels, Heluna Health may reduce, suspend, or terminate any cash, reimbursements, other payments, or allocations of funds provided to the State.

(b) Advance payment. Advance payments may be requested by the State by submitting an invoice for the amount of the advance. The State must liquidate or offset the amount of the advance with invoices before the end of each budget year/period.

I. The State agrees to remit any unexpended advance payment balance to HELUNA HEALTH within forty-five (45) calendar days following the submission of the Contractor's final invoice.

(c) Must Stay Within Budget Time Periods. The State shall be compensated only for Services actually performed by the State and within the appropriate time period set forth in this agreement.

(d) Funds Available to HELUNA HEALTH. In the event the federal grant is terminated or federal funds are not available, HELUNA HEALTH shall notify the State in writing. It is mutually agreed that if federal funds are not available for the current year and/or any subsequent years covered under this Agreement, this Agreement may be terminated by either Party pursuant to section 6 of this Agreement, or the Parties may agree to amend this Agreement to reflect the reduced amount.

(e) Billing of Expenses and Costs. All expenses and costs shall be billed in accordance with the approved budget. Expenses incurred after the expiration or termination of this Agreement shall be disallowed. The State shall submit its final invoice no later than 30 days after the date of expiration of the term or termination of this Agreement.

(f) Budget Modifications. The Budget may be modified only by written agreement of HELUNA HEALTH and the State and the prior written approval of the Funding Agency.

(g) Subaward Start-up Costs: The State is requesting startup costs **not to exceed $71.5 million dollars.** These funds will be disbursed to Local Health Jurisdictions (LHJs) to assist in their objectives, deliverables and performance measures as outlined in their individual work plan as contracted with the State. The State will submit an invoice that will include each LHJ's invoice and allocation letter for startup costs. Based upon the invoice submission by the State, Heluna Health will draw down advance funds. The advanced funds will be fully disbursed via check to the State. Upon receipt of advanced funds, the State will fully disburse advanced funds to each LHJ no later than the close of business the following work day. On a monthly basis, the State will provide Heluna Health with an invoice that will include documentation of the advanced funds being disbursed to the LHJs along with proof of payment which includes transmittal date.

5. INVOICING PROCEDURES

(a) Address for Invoices. The State shall send all invoices to the attention of the HELUNA HEALTH Project Director at the address set forth in Section 1 above.

(b) Invoicing Period. All invoices shall be submitted not more frequently than monthly, in arrears and must be submitted to HELUNA HEALTH within 30 days after the end of the applicable month or within 15 days after approval by the Funding Agency (if applicable), whichever is later. All final invoices must be received within 30 days of the expiration or termination of this Agreement. If any invoices are not submitted within such time periods, the State waives (in HELUNA HEALTH's discretion) all rights to payment under such invoices.

(c) Formatting and Requirements of Invoices. All invoices shall be submitted in the form attached hereto as Exhibit D, as it may be modified by HELUNA HEALTH from time to time. Heluna Health shall provide notice of modifications to the form and a copy of the new form to the State 30 days in advance.

6. TERM AND TERMINATION

(a) Term. Unless earlier terminated as provided herein, the term of this Agreement shall be from May 18, 2020 to November 17, 2022 (the "Term").

(b) Termination Without Cause. Without cause, either Party may terminate this Agreement by giving 30 days' prior written notice to the other Party of its intent to terminate this Agreement without cause. Agreement termination shall be effective as of the date indicated in the notice.

(c) Termination for Cause. With reasonable cause, either Party may terminate this Agreement effective immediately upon the giving of written notice of termination for cause. Reasonable cause shall include:

i. A material violation or breach of this Agreement by the other Party which is not cured within 15 days after written notice from the terminating Party;

ii. Any act of the other Party that exposes the terminating Party to liability to others for personal injury or property damage or any other harm, damage or injury; or

iii. If either Party receives notice from the Funding Agency of the cancellation or termination of, or reduction of funding under, the Funding Award Agreement affecting the Services.

(d) Termination for Lack of Funding. HELUNA HEALTH may terminate this Agreement if for any reason the funding available under the Funding Award Agreement is withdrawn, limited, or impaired. The State shall refund any excess or advance payments not invoiced within ten (10) business days following written notice.

(e) Cessation Upon Termination. On the effective date of termination, the State shall cease all further Services under this Agreement, and the State shall cancel as many outstanding obligations as possible and not incur any additional obligations.

(f) Surviving Provisions. The provisions of Sections 7 through 16, and any other sections that by their nature should or are intended to survive the expiration or termination of this Agreement shall survive and the Parties shall continue to comply with the provisions of this Agreement that survive.

7. REPRESENTATIONS AND WARRANTIES. The State represents, warrants and covenants to HELUNA HEALTH as follows:

(b) Qualifications and Performance. The State (i) has the experience and skill to perform the Services hereunder, (ii) shall perform the Services in a good and workman like manner and in accordance with generally accepted professional standards and in an expeditious and economical manner consistent with sound professional practices, and (iii) is adequately financed to meet any financial obligation it may be required to incur hereunder.

8. INDEPENDENT CONTRACTOR STATUS

(a) Independent Contractor. Nothing in this Agreement is intended to place the Parties in the relationship of employer-employee, partners, joint ventures, or in anything other than an independent contractor relationship. It is the Parties' intention that the State shall be an independent contractor and not HELUNA HEALTH's employee or agent, and in conformity

therewith, that the State shall retain sole and absolute discretion and judgment in the manner and means of carrying out the State's Services hereunder.

(b) No Power to Bind HELUNA HEALTH. Without limiting the generality of the foregoing paragraph, this Agreement does not designate the State as the agent or legal representative of HELUNA HEALTH for any purpose whatsoever. The State is not granted any right or authority to assume or create any obligation or responsibility, or to make any promise or commitment regarding any work, on behalf of or in the name of HELUNA HEALTH or to bind it in any manner, or to make any contract or agreement on behalf of or in the name of HELUNA HEALTH, without the prior written consent from HELUNA HEALTH management. No sales, invoices nor orders for goods or services shall be valid and binding upon HELUNA HEALTH (whether as the provider or the recipient) unless and until accepted by HELUNA HEALTH, at its sole and absolute discretion, through its established channels.

(c) No Withholding. Except for tax withholdings that are required by law, neither federal, nor state, nor local income tax nor payroll taxes of any kind shall be withheld or paid by either Party on behalf of the other or the employees of the other. The State and its personnel shall not be treated as employees of HELUNA HEALTH with respect to the Services performed hereunder for federal or state tax purposes or for any other purposes.

(d) No Employee Benefits. Neither Party nor its personnel shall be eligible for, and shall not participate in, any of the other Party's retirement, health, or other fringe benefit plans.

(e) Workers' Compensation. No workers' compensation insurance shall be obtained by either Party concerning the other's personnel. Each Party shall comply with all workers' compensation laws concerning its personnel.

9. PUBLICATIONS

Use of HELUNA HEALTH's or Funding Agency's Name. The State shall not use in any manner HELUNA HEALTH's name, logo or trademarks without HELUNA HEALTH's prior written consent. The State shall not use in any manner the Funding Agency's name, logo or trademarks without the Funding Agency's prior written consent.

10. INDEMNIFICATION

HELUNA HEALTH agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims, demands, losses, causes of action, damage, lawsuits, judgments, including attorneys' fees and costs arising out of or relating to the work of any and all HELUNA HEALTH's employees, officers, agents, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies under HELUNA HEALTH's control, in connection with the performance of the ELC programs and activities, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or

damaged by HELUNA HEALTH in the performance of the ELC Cooperative Agreement. Parties expressly agree that LHJs are excluded from HELUNA HEALTH's indemnification obligation.

11. CONFIDENTIALITY

(a) **HELUNA HEALTH Confidential Information.** The State agrees that during the course of this Agreement, the State may be exposed to and become aware of certain unique and confidential information and special knowledge (hereinafter "HELUNA HEALTH Confidential Information") provided to or developed by HELUNA HEALTH. Said HELUNA HEALTH Confidential Information includes, but is not limited to, the identity of actual and potential clients of HELUNA HEALTH, client lists, particular needs of each client, the manner in which business is conducted with each client, addresses, telephone numbers, and specific characteristics of clients; financial information about HELUNA HEALTH and/or its clients; client information reports; mailing labels; various sales and marketing information; sales report forms; pricing information (such as price lists, quotation guides, previous or outstanding quotations, or billing information); pending projects or proposals; business plans and projections, including new product, facility or expansion plans; employee salaries; contracts and wage information; mailing plans and programs; technical know-how; designs; products ordered; business methods; processes; records; specifications; computer programs; accounting; and information disclosed to HELUNA HEALTH by any third Party which HELUNA HEALTH is obligated to treat as confidential and/or proprietary. This HELUNA HEALTH Confidential Information derives independent actual or potential economic value from not being generally known to the public or to other persons, who can obtain economic value from its disclosure or use, is not readily available through any source other than HELUNA HEALTH and is the subject of reasonable efforts to maintain secrecy. Since the State may be exposed to and become aware of said HELUNA HEALTH Confidential Information and, because of its unique and confidential nature, the Parties hereto desire to afford HELUNA HEALTH protection against its unauthorized use or its use in any manner detrimental to HELUNA HEALTH. Therefore, the State shall not disclose in any manner whatsoever any of the aforesaid HELUNA HEALTH Confidential Information, directly or indirectly, or use it in any way whatsoever, either during this Agreement or at any time thereafter, except as required in the course of the State's work with HELUNA HEALTH or except as otherwise provided in this Agreement. Further, the State shall develop and maintain procedures and take other reasonable steps in furtherance of HELUNA HEALTH's desire to maintain the confidentiality of its HELUNA HEALTH Confidential Information. The Parties mutually agree that in the event of a breach or threatened breach of this Agreement, the other party may suffer irreparable harm for which it may not have an adequate remedy at law. Therefore, the injured Party shall have the right to seek injunctive relief to enforce this Agreement, in addition to its other rights or remedies which may be available at law or in equity.

(b) **Exceptions to HELUNA HEALTH Confidential Information.** HELUNA HEALTH Confidential Information shall not include and this Agreement shall not impose any obligation upon the State with respect to information which the State can establish by documentary or other competent evidence:

i. is or becomes generally available to the public through no fault of the State; or

ii. was rightfully in the possession of the State prior to its receipt from HELUNA HEALTH; or

iii. is disclosed with the prior written consent of HELUNA HEALTH; or

iv. was independently developed by the State without use of the HELUNA HEALTH Confidential Information by persons who did not have access to the HELUNA HEALTH's Confidential Information.

For the purposes of this Agreement, disclosures which provide specific, detailed information shall not be deemed to be within the foregoing exceptions merely because they are embraced by more general disclosures in the public domain or in the State's possession. In addition, any combination of features or components shall not be deemed to be within the foregoing exceptions merely because information about individual components are separately in the public domain or in the State's possession.

(c) **Funding Agency Confidentiality.** The State shall also comply with all confidentiality obligations imposed by the Funding Agency in the Funding Award Agreement or otherwise.

(d) **Return of Documents.** All documents and other items which might be deemed the subject of or related to HELUNA HEALTH Confidential Information of HELUNA HEALTH's business shall remain the exclusive property of HELUNA HEALTH and shall not be copied or removed from the premises of HELUNA HEALTH without the express written consent of HELUNA HEALTH. All such items, and any copies thereof, shall be immediately returned to HELUNA HEALTH by the State upon request at any time and upon termination of this Agreement.

(e) **Mutual Privacy and Security Requirements.** The attached Information Privacy and Security Requirements in Exhibit E shall apply to all PCI (as defined in Exhibit E, Attachment I) accessed, used, received, or disclosed by either Party and are incorporated here by reference. Both Parties agree to apply the terms of the Information Privacy and Security Requirements to all agents or subcontractors who access, use, receive, or disclose PCI which is owned by CDPH.

12. RECORD RETENTION AND ACCESS TO RECORDS

The State shall grant to the Funding Agency and the U.S. Comptroller General and their respective authorized representatives upon demand, access to any books, documents, papers and records of the State relating to this Agreement or the Services for audit, examination, excerpt and transcription, as permitted by law. The State shall retain all such records for seven (7) years (or longer if required under the Funding Award Agreement or by law, including under Circular A-110, Subpart C, Post-Award Requirements and FAR Subpart 4.7 Contractor Records

Retention - 4.703 Policy) after final payment is made under this Agreement and all pending matters are closed, unless extended by an audit, litigation, or other action involving the records, whichever is later.

13. GENERAL TERMS

(a) Amendments. Amendments to this Agreement shall be in writing, signed by the Parties, and attached to this Agreement.

(b) Governing Law; Venue. This Agreement shall be interpreted, construed and governed by, in accordance with and consistent with the laws of the State of California without giving effect to its conflicts of laws principals.

(c) Equitable Relief. In light of the irreparable harm to HELUNA HEALTH that a breach by the State of Sections 9, 10, 13 and 14 of this Agreement would cause, in addition to other remedies set forth in this Agreement and other relief for violations of this Agreement, HELUNA HEALTH shall be entitled to enjoin the State from any breach or threatened breach of such Sections, to the extent permitted by law and without bond.

(d) Binding Agreement. All terms, conditions and covenants to be observed and performed by the Parties hereto shall be applicable to and binding upon their respective agents, employees, heirs, executors, administrators, affiliates, subsidiaries, associates, employees, successors and assigns.

(e) Captions. All captions (section headings) set forth herein are inserted only as a matter of convenience and for reference, and shall not affect the interpretation of this Agreement.

(f) Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original but all of which, when taken together, shall constitute one and the same document.

(g) Additional Documents. The Parties hereto each agree that they shall execute and, if appropriate, acknowledge any and all additional and other documents, instruments and writings which may be reasonably requested by the other Party in order to fully carry out the intent and purpose of this Agreement.

(h) Attorneys' Fees; Costs. In the event that any suit in law or equity, arbitration or other formal proceeding is instituted by any Party to enforce or interpret any part of this Agreement, or to recover damages for breach thereof, the prevailing Party shall, in addition to any such other relief available to such Party, be entitled to recover costs of suit incurred therein, and to also recover as an element of such costs (but not as damages) reasonable attorneys' fees incurred by such prevailing Party.

(i) Entire Agreement. This Agreement, and all documents referred to in it, or incorporated in it, is an integrated document containing and expressing all terms, covenants, conditions, warranties and agreements of the Parties relating to the subject matter hereof. No other or prior agreements or understandings, written or oral, pertaining to the same shall be valid or of any force or effect.

(j) Facsimile or Email Transmissions. A facsimile transmission or transmission by Email of the executed signature page of this Agreement shall be accepted as, relied upon as, and deemed to be, an original.

(k) Fair Interpretation. The language appearing in all parts of this Agreement shall be construed, in all cases, according to its fair meaning in the English language, and not strictly construed for or against any Party hereto. This Agreement has been prepared jointly by the Parties hereto after arm's length negotiations and any uncertainty or ambiguity contained in this Agreement, if any, shall not be interpreted or construed against any Party, but according to its fair meaning applying the applicable rules of interpretation and construction of contracts.

(l) No Waiver. No failure or delay by any Party in exercising a right, power or remedy under the Agreement shall operate as a waiver of any such right or other right, power or remedy. No waiver of, or acquiescence in, any breach or default of any one or more of the terms, provisions or conditions contained in this Agreement shall be deemed to imply or constitute a waiver of any other or succeeding or repeated breach or default hereunder. The consent or approval by any Party hereto to or of any act of the other Party hereto requiring further consent or approval shall not be deemed to waive or render unnecessary any consent or approval to or of any subsequent similar acts.

(m) Notices. Any notice, demand, consent or other communication required or permitted to be given hereunder shall be made in the English language and shall be so given by personal delivery, by (i) registered or certified (return receipt) or First Class United States Postal Service mail, postage pre-paid, or (ii) recognized overnight national courier service, or (iii) facsimile transmission confirmed by letter sent by First Class United States Postal Service mail, postage pre-paid, or (iv) by email confirmed by letter sent by First Class United States Postal Service mail, postage pre-paid, addressed to the recipient of such notice at the following address or facsimile number, as the case may be, or any other address or facsimile number or email address provided by a Party in the manner described hereinabove:

In the case of HELUNA HEALTH, addressed to:

Heluna Health

[redacted]

Email: [redacted]@helunahealth.org
Contracts@HelunaHealth.org

In the case of the State, addressed to:

California Department of Public Health
[redacted]
Email: [redacted]@cdph.ca.gov

Any such notice shall be deemed to have been received by the addressee, and service thereof shall be deemed effective, five (5) days following deposit thereof with the United States Postal Service, or upon actual receipt, whichever first occurs, unless the address for delivery is not within one of the United States or its territories or possessions, in which case service shall be effective seven (7) days following deposit, or upon actual receipt, whichever first occurs.

(n) Force Majeure. Neither Party will be held liable for failure to fulfill its obligations hereunder if such failure is due to, an act of war; domestic and/or international terrorism; civil riots or rebellions; or extraordinary elements of nature or acts of God; is beyond the excused Party's reasonable control, occurs without the excused Party's fault or negligence, is not caused directly or indirectly by the excused Party and could not have been prevented or avoided by the excused Party's reasonable diligence. Due to the nature and scope of this contract for COVID-19 pandemic response, both parties will be required to work together to avoid delays as reasonably as possible. If delays do occur as a result, it will be incumbent for both parties to work together and provide solutions.

(o) Remedies Non-Exclusive. Except where otherwise expressly set forth herein, all remedies provided by this Agreement shall be deemed to be cumulative and additional and not in lieu of or exclusive of each other or of any other remedy available to the respective Parties at law or in equity.

(p) Severability. If any term, provision, condition or other portion of this Agreement is determined to be invalid, void or unenforceable by a forum of competent jurisdiction, the same shall not affect any other term, provision, condition or other portion hereof, and the remainder of this Agreement shall remain in full force and effect, as if such invalid, void or unenforceable term, provision, condition or other portion of this Agreement did not appear herein.

(q) Limitation of Liability. IN NO EVENT SHALL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE OR CONSEQUENTIAL DAMAGES,

WHETHER BASED ON BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHERWISE, AND WHETHER OR NOT THAT PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGE.

(r) Non-Assignability. None of the Parties shall assign, transfer, sell, encumber, hypothecate, alienate or otherwise dispose of this Agreement, or any right, title or interest to or in this Agreement, nor shall a Party delegate any duty or obligation to be performed hereunder, without the express written consent of the other Party having been first obtained, except that any Party may assign this Agreement without the consent of the other Party in the case of a reorganization, merger, consolidation, or sale of all or substantially all of its assets so long as the assignee expressly assumes all of the obligations of the assignor under this Agreement.

(s) Signing Person. The individuals signing this Agreement on behalf of an entity represents and warrants that he/she has authority to bind such entity to this Agreement.

[Signatures follow on next page]

The undersigned have caused this Agreement to be executed as of the date first set forth above:

[redacted]

8/7/20
Date

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

[redacted]
Date: 2020.08.08 08:29:00 -07'00'

[redacted]

Date

EXHIBIT A
TO THE STATE AGREEMENT

SCOPE OF WORK (SOW)

Goal:
To address identified gaps (public health workforce, laboratory testing, surveillance, contact tracing, and expanding key partnerships) to ensure that the California Department of Public Health (CDPH) can move farther and quicker in preparation for increased disease transmission across the state associated with reopening, with a specific lens on addressing the needs of those most at risk for exposure to COVID-19 and/or severe outcomes.
CDPH will ensure that all activites and milestones in the ELC Enhancing Detection/PPPHCEA application are completed with a focus on the following objectives and activities:

A. ***Objective 1:*** Support additional state and local response workforce.
   1. *Major Functions, Tasks, and Activities:*
      a. Increase capacity for case investigation and contact tracing at the state and local levels.
      b. Increase capacity for disease control activities by:
         i. Conducting public outreach to promote non-pharmaceutical interventions.
         ii. Expanding local public health infection control capacity.
         iii. Supporting isolation and quarantine efforts through local partnerships.

   2. *Timeline:* May 2020 – December 2022.

   3. *Deliverables/ Performance Measures:*
      a. In collaboration with Local Health Jurisdictions (LHJs), CDPH will determine an allocation formula to distribute funds to assist the scale up of local contact tracing program staff by July 2020.
      b. CDPH will execute contracts with 58 county local health departments (LHDs) to expand their local contact tracing efforts by August 2020.
      c. Conduct LHJ Infection Prevention and Control (IPC) needs assessment interviews and hold LHJ focus groups to identify training and resource needs for the LHJ Infection Prevention (IP) and mechanisms for coordination with CDPH Health Care Associated Infections (HAI) Program IP teams by July 2020.
      d. Using findings from the LHJ IPC needs assessment and focus groups, create and provide a written summary and presentation on roles and best practices for the LHJ IP and framework for support and coordination with CDPH HAI Program IP teams by August 2020.
      e. Establish mentorship and collaborative partnerships between LHJ IP and CDPH HAI IP teams by assigning specific LHJs to each HAI IP team by September 2020.
      f. Engage California HAI Advisory Committee members regarding potential academic and health systems (e.g., Kaiser) partnerships for

expanding local IPC consultation and support services in coordination with LHJ IP and CDPH HAI Program IP teams by September 2020.

g. Conduct an analysis of occupational risks associated with COVID-19 to inform occupational guidelines and strategic plans by September 2021.

B. ***Objective 2:*** Expand laboratory capacity in CDPH and local public health laboratories.

1. *Major Functions, Tasks, and Activities:*
    a. Improve public health laboratory data systems.
    b. Enhance coordination for COVID-19 response with local public health laboratories in California.
    c. Support expanded testing capacity.
    d. Support improved information systems in local public health laboratories.
    e. Support training for local public health laboratories.

2. *Timeline:* May 2020 – December 2022.

3. *Deliverables/ Performance Measures:*
    a. Assess Public Health Laboratories' (PHLs) current capacity and needs for laboratory information management systems and electronic test reporting software by September 2020.
    b. Work with local PHLs to develop goals for LIMS software functionality, web portals and interfaces needed by November 2020.
    c. Develop and implement plan to distribute local allocations for COVID-19 data management and analytic capacity improvement to local Public Health Departments by December 2020.
    d. Implement an electronic data exchange user feedback system to provide detailed quality assurance of successful and accurate PHL data transmission by June 2021.
    e. Procure high throughput molecular and serology equipment to increase and expand COVID-19 testing capacity at the State PHL (Viral and Rickettsial Disease Laboratory or VRDL) for diagnostic testing, sero-surveillance, and community surveillance studies by September 2020.
    f. Coordinate with CA Network of local PHLs to procure high throughout molecular and serology equipment to increase and expand COVID-19 testing capacity throughout the State for diagnostic testing, sero-surveillance, and community surveillance studies by September 2020.
    g. Maintain/extend the current contract with OptumServe and Verily for community collection/testing sites by July 2020.

h. Establish mobile collection and/or testing units for community testing in hot spots - strike teams for rapid deployment to areas of concern (e.g., congregate settings, rural communities, migrant worker sites) by September 2020.
i. Coordinate with local PHLs to link up with mobile sample collection operations/clinics to receive specimens for quick testing turnaround times and resulting by October 2020.

C. ***Objective 3:*** Enhance statewide COVID-19 surveillance.
1. *Major Functions, Tasks, and Activities:*
a. Implement additional surveillance strategies.
b. Improve disease reporting data systems.
c. Support case investigation efforts that will increase completeness of data on race and ethnicity and other demographic factors.
d. Data on contact tracing will be added to CDPH dashboards.
e. Initiate enhanced surveillance activities to collect data on seroprevalence and prevalence of SARS-CoV-2 among asymptomatic persons and persons with Influenza-like Illness (ILI) across California.
f. Make data available to stakeholders pursuant to state and federal privacy laws.
g. Collect data on the indirect impacts of the COVID-19 pandemic as well as the causes of COVID-19 health disparities and publish.
h. Enhance local capacity to collect surveillance data and make them available.

2. *Timeline:* May 2020 – December 2022.

3. *Deliverables/ Performance Measures:*
a. Build a California public health workforce to conduct other enhanced surveillance systems that includes hiring and training a CDPH team of 2 Medical Epidemiologists, 2 PhD Epidemiologists, and 10 MPH Epidemiologists and partner with local academic universities by September 2020.
b. Systematically collect and report epidemiologic and laboratory data from the LHJ community surveillance sites and population-based serosurvey in an automated daily fashion as required by CDC and with integration into other CDPH data reporting systems by October 2020.

c. Receive and process electronic case reports for SARS-CoV-2 and other conditions of public health significance into the statewide surveillance system on a daily basis by October 2020.

D. ***Objective 4:*** Address the disproportionate impact of COVID-19 on some populations, which is central to public health's response activities.

1. *Major Functions, Tasks, and Activities:*
    a. Assess and monitor infections in healthcare workers across the healthcare spectrum.
    b. Monitor cases and exposure to COVID-19 to identify need for targeted mitigation strategies to isolate and prevent further spread within high-risk healthcare facilities (e.g., hospitals, dialysis clinics, cancer clinics, nursing homes, and other long-term care facilities, etc.).
    c. Monitor cases and exposure to COVID-19 to identify need for targeted mitigation strategies to isolate and prevent further spread within high-risk employment settings (e.g., meat processing facilities), and congregate living settings (e.g., prisons, youth homes, shelters).
    d. Work with LHDs to build local capacity for reporting, rapid containment and prevention of COVID-19/SARS-CoV-2 within high-risk settings or in vulnerable populations that reside in their communities.
    e. Build capacity for IPC in Long-Term Care Facilities (LTCF) (e.g., at least one IP for every facility) and outpatient settings.

2. *Timeline:* May 2020 – December 2022.

3. *Deliverables/ Performance Measures:*
    a. Determine allocation process for distributing funding to LHJs to support communities of color in low-income areas with supportive services for isolation and quarantine by August 2020.
    b. In partnership with LHJs, develop strategies and tools for a comprehensive approach to reach vulnerable populations to support communities of color in low-income areas with supportive services for isolation and quarantine by September 2020.
    c. Monitor progress of LHJs quarterly to support communities of color in low-income areas for isolation and quarantine.
    d. Conduct a competitive process to allocate $5 million for pilot projects to community based organizations and non-profits by July 2020.
    e. CDPH to execute contract with 15-20 Community Based Organizations or non-profits for pilot projects by September 2020.

f. Develop Best Practices document based on the outcomes of the pilot projects by January 2021.

E. ***Objective 5:*** Fund LHJs through grants or contracts allocated based on local population and specific factors related to COVID-19 (e.g., disease incidence or levels of disparity in different populations).

1. *Major Functions, Tasks, and Activities:*
   a. Local funding allocation formulas will be developed with input from LHJs.
   b. Provide support to LHJs:
      i. Guidance development.
      ii. Expert consultation.
      iii. Training.
      iv. Provision of surge staffing.
      v. Purchasing and distribution of supplies.
      vi. Laboratory testing.
      vii. Coordination and communication support.

2. *Timeline:* May 2020 – December 2022.

3. *Deliverables/ Performance Measures:*
   a. Determine allocation formula to distribute $30 Million to local health jurisdictions in collaboration with key stakeholder groups by July 2020.
   b. Establish contracts with local health jurisdictions for IPC activities by August 2020.
   c. Hire three full time employees for a 24 month term by August 2020.
   d. In collaboration with local health jurisdictions, conduct investigations of workplace COVID-19 clusters, evaluate exposures, offer technical assistance, and make recommendations to minimize risk of transmission. Prioritize workplace settings affecting large numbers of workers at high risk for COVID-19 exposure and overall health disparities (e.g., food production, services sector, warehousing, manufacturing). As possible, conduct outreach to these sectors to promote use of effective prevention measures by September 2020.

F. ***Objective 6:*** Support coordination of California Connected, the statewide contact tracing program.

1. *Major Functions, Tasks, and Activities:*
   a. Train state and local staff through virtual training academy.
   b. Deploy state personnel to enhance local contact tracing activities.

2. *Timeline:* May 2020 – December 2022.

3. *Deliverables/ Performance Measures:*
   a. The Reporting and Analytics team will oversee the collection and analysis of surveillance data, informatics, evaluation, and quality assurance of the program and quality management oversight of the expanded contact tracing workforce by August 2020.
   b. The Training and Workforce Development Team will provide oversight of the Virtual Training Academy for case investigators and contact tracers, provide ongoing training and support for the contact tracing supervisors, develop and implement a plan for additional workforce training needs on cultural competency and other skill-based enhances training, and manage workforce surge needs by August 2020.
   c. The Local Capacity and Local Health Jurisdiction Support team will assess local health jurisdiction needs and gaps, provide technical support in addressing barriers or contact tracing staffing needs, and provide programmatic technical assistance for local grants by July 2020.
   d. The Medical and Scientific Affairs Team will develop program policy and response, provide clinical, public health, and programmatic consultation to local health jurisdictions, develop guidance for LHJs and providers, and provide clinical expertise to program teams by August 2020.
   e. The Communications and Social Media Team collaborates with the California Office of Public Affairs and the Governor's Office on public communications and campaigns, develops and implements the communication plan for the LHJs and other stakeholders, and maintains and updates the public website by August 2020.
   f. CDPH to hire staff to support the implementation of the statewide contact tracing program by August 2020.
   g. CDPH will work with Heluna Health to ensure timely monthly, quarterly and annual reporting, including progress reports, performance measures, and any other ELC required data or program reporting.

EXHIBIT B
TO THE STATE AGREEMENT

BUDGET

FY 2020-21
Exhibit B - BUDGET

	ELC CDPH Budget							
1.	**Personnel**							
	Position Title	**Monthly Salary**	**FTE**	**Benefits**	**YEAR 1 May 20-April 21**	**YEAR 2 May 21-April 22**	**YEAR 3 May 22-Nov 22**	**Total**
	EPO - Staff Services Manager I (Spec)	$ 6,124	1.0	55.34%	$ 73,488	$ 73,488	$ 42,872	$ 189,848
	Admin - Staff Services Manager I	$ 6,430	1.0	55.34%	$ 77,160	$ 73,488	$ 45,014	$ 195,662
	EPO - Associate Governmental Program Analyst	$ 5,676	1.0	55.34%	$ 68,112	$ 68,112	$ 39,736	$ 175,960
	EPO - Associate Governmental Program Analyst	$ 5,676	1.0	55.34%	$ 68,112	$ 68,112	$ 39,736	$ 175,960
	EPO - Associate Governmental Program Analyst	$ 5,676	1.0	55.34%	$ 68,112	$ 68,112	$ 39,736	$ 175,960
	Admin - Associate Governmental Program Analyst	$ 5,676	1.0	55.34%	$ 68,112	$ 68,112	$ 39,736	$ 175,960
	Admin - Associate Governmental Program Analyst	$ 5,676	1.0	55.34%	$ 68,112	$ 68,112	$ 39,736	$ 175,960
	EPO - Health Program Specialist I	$ 5,818	1.0	55.34%	$ 69,816	$ 69,816	$ 40,730	$ 180,362
	OHE - Health Program Specialist II	$ 6,995	1.0	55.34%	$ -	$ 83,940	$ 48,969	$ 132,909
			9.0					
	1. Personnel Subtotal				***$ 561,024***	***$ 641,292***	***$ 376,264***	***$ 1,578,580***
2.	**Equipment**							
	Strengthen Viral and Rickettsial Disease Lab (CDPH) Equipment and Supplies (Increase to high thru put of 1000 tests for PCR and allows serology testing in larger numbers)				$ 1,000,000	$ 2,000,000	$ 1,000,000	$ 4,000,000
	2. Equipment Subtotal				***$ 1,000,000***	***$ 2,000,000***	***$ 1,000,000***	***$ 4,000,000***
3.	**Supplies**							
	General Expense ($4000/FTE)				$ 32,000	$ 36,000	$ 21,000	$ 89,000
	Printing ($2000/FTE)				$ 16,000	$ 18,000	$ 10,500	$ 44,500
	3. Supplies Subtotal				***$ 48,000***	***$ 54,000***	***$ 31,500***	***$ 133,500***
4.	**Travel (In-State)**							
	CDPH Staff Cost ($3000/FTE)				$ -	$ 3,000	$ 2,000	$ 5,000
	4. Travel (In-State) Subtotal				***$ -***	***$ 3,000***	***$ 2,000***	***$ 5,000***
5.	**Travel (Out-of-State)**							
	Not Applicable				$ -	$ -	$ -	$ -
	5. Travel (Out-of-State) Subtotal				***$ -***	***$ -***	***$ -***	***$ -***
6.	**Other**							
	Replacement for CalREDIE system, short term solution and long term build includes project management, system build, etc.				$ 12,400,000	$ 24,800,000	$ 12,400,000	$ 49,600,000
	CDPH Staff Facilities Costs ($11,000/FTE)				$ 88,000	$ 99,000	$ 57,750	$ 244,750
	Lab Staff Facilities Costs ($30,000/FTE) for Emerging Detection				$ 90,000	$ 90,000	$ 52,500	$ 232,500
	Lab Staff Facilities Costs ($30,000/FTE) for ELC CARES				$ 180,000	$ 180,000	$ 105,000	$ 465,000
	CDPH Staff Communications Costs ($2000/FTE)				$ 16,000	$ 18,000	$ 10,500	$ 44,500
	CDPH Staff Consolidated Data Center Costs ($1000/FTE)				$ 8,000	$ 9,000	$ 5,250	$ 22,250
	CDPH Staff IT Bundle ($7000/FTE)				$ 56,000	$ 63,000	$ 36,750	$ 155,750
	SAS Lisences for HH Staff ($642/25 FTE)				$ 16,050	$ 16,050	$ 16,050	$ 48,150
	Accurint/Lexis Nexis Licenses (4 licenses@ $90/person/month				$ 4,320	$ 4,320	$ 4,320	$ 12,960
	IT Services for Heluna Health Staff ($7000/18 FTE) other HAI				$ 126,000	$ 126,000	$ 73,500	$ 325,500
	IT Services for Heluna Health Staff ($7000/54 FTE) other Emerging Infectious Disease				$ 378,000	$ 378,000	$ 220,500	$ 976,500
	IT Services for Heluna Health Staff ($7000/80 FTE) Enhancing Detection				$ 560,000	$ 560,000	$ 326,667	$ 1,446,667
	6. Other Subtotal				***$ 13,922,370***	***$ 26,343,370***	***$ 13,308,787***	***$ 53,574,527***
7.	**Subcontracts**							
	A. Local-Level Subontracts							
	Alameda				$ 4,393,667	$ 4,393,667	$ 2,929,112	$ 11,716,447
	Alpine				$ 574,071	$ 574,071	$ 382,714	$ 1,530,856
	Amador				$ 644,248	$ 644,248	$ 429,499	$ 1,717,995
	Berkeley				$ 804,957	$ 804,957	$ 536,638	$ 2,146,553
	Butte				$ 1,449,882	$ 1,449,882	$ 966,588	$ 3,866,351
	Calaveras				$ 657,143	$ 657,143	$ 438,096	$ 1,752,382
	Colusa				$ 613,675	$ 613,675	$ 409,116	$ 1,636,466
	Contra Costa				$ 3,356,414	$ 3,356,414	$ 2,237,609	$ 8,950,438
	Del Norte				$ 623,661	$ 623,661	$ 415,774	$ 1,663,096
	El Dorado				$ 934,456	$ 934,456	$ 622,970	$ 2,491,882
	Fresno				$ 3,471,287	$ 3,471,287	$ 2,314,191	$ 9,256,765
	Glenn				$ 626,933	$ 626,933	$ 417,955	$ 1,671,820
	Humboldt				$ 1,202,646	$ 1,202,646	$ 801,764	$ 3,207,056
	Imperial				$ 851,895	$ 1,381,466	$ 920,977	$ 3,154,338
	Inyo				$ 607,015	$ 607,015	$ 404,676	$ 1,618,706

FY 2020-21
Exhibit B - BUDGET

	Kern				$ 2,303,935	$ 2,303,935	$ 1,535,957	$ 6,143,826
	Kings				$ 705,572	$ 862,377	$ 574,918	$ 2,142,868
	Lake				$ 694,855	$ 694,855	$ 463,237	$ 1,852,947
	Lassen				$ 628,857	$ 628,857	$ 419,238	$ 1,676,951
	Madera				$ 873,388	$ 873,388	$ 582,259	$ 2,329,035
	Marin				$ 1,068,700	$ 1,068,700	$ 712,467	$ 2,849,866
	Mariposa				$ 606,022	$ 606,022	$ 404,015	$ 1,616,060
	Mendocino				$ 740,096	$ 740,096	$ 493,398	$ 1,973,591
	Merced				$ 1,106,591	$ 1,106,591	$ 737,728	$ 2,950,910
	Modoc				$ 590,022	$ 590,022	$ 393,348	$ 1,573,392
	Mono				$ 597,608	$ 597,608	$ 398,406	$ 1,593,622
	Monterey				$ 1,901,180	$ 1,901,180	$ 1,267,453	$ 5,069,812
	Napa				$ 837,939	$ 837,939	$ 558,626	$ 2,234,503
	Nevada				$ 758,797	$ 758,797	$ 505,865	$ 2,023,460
	Orange				$ 7,674,695	$ 7,674,695	$ 5,116,463	$ 20,465,854
	Placer				$ 1,321,596	$ 1,321,596	$ 881,064	$ 3,524,257
	Plumas				$ 609,256	$ 609,256	$ 406,171	$ 1,624,683
	Riverside				$ 5,933,557	$ 5,933,557	$ 3,955,705	$ 15,822,819
	Sacramento				$ 4,544,047	$ 4,544,047	$ 3,029,365	$ 12,117,460
	San Benito				$ 689,611	$ 689,611	$ 459,740	$ 1,838,961
	San Bernardino				$ 5,502,502	$ 5,502,502	$ 3,668,335	$ 14,673,338
	San Diego				$ 7,769,041	$ 7,769,041	$ 5,179,361	$ 20,717,444
	San Francisco				$ 2,692,332	$ 2,692,332	$ 1,794,888	$ 7,179,553
	San Joaquin				$ 2,665,355	$ 2,665,355	$ 1,776,903	$ 7,107,612
	San Luis Obispo				$ 1,514,300	$ 1,514,300	$ 1,009,534	$ 4,038,134
	San Mateo				$ 2,560,603	$ 2,560,603	$ 1,707,069	$ 6,828,275
	Santa Barbara				$ 2,256,027	$ 2,256,027	$ 1,504,018	$ 6,016,073
	Santa Clara				$ 5,315,354	$ 5,315,354	$ 3,543,569	$ 14,174,276
	Santa Cruz				$ 1,091,364	$ 1,091,364	$ 727,576	$ 2,910,304
	Shasta				$ 1,397,245	$ 1,397,245	$ 931,497	$ 3,725,986
	Sierra				$ 577,947	$ 577,947	$ 385,298	$ 1,541,193
	Siskiyou				$ 656,136	$ 656,136	$ 437,424	$ 1,749,696
	Solano				$ 1,893,418	$ 1,893,418	$ 1,262,278	$ 5,049,114
	Sonoma				$ 1,968,119	$ 1,968,119	$ 1,312,080	$ 5,248,319
	Stanislaus				$ 1,414,333	$ 1,628,297	$ 1,085,531	$ 4,128,161
	Sutter				$ 756,125	$ 756,125	$ 504,083	$ 2,016,333
	Tehama				$ 693,562	$ 693,562	$ 462,375	$ 1,849,500
	Trinity				$ 597,744	$ 597,744	$ 398,496	$ 1,593,985
	Tulare				$ 1,889,867	$ 1,889,867	$ 1,259,911	$ 5,039,645
	Tuolumne				$ 675,047	$ 675,047	$ 450,031	$ 1,800,125
	Ventura				$ 2,640,792	$ 2,640,792	$ 1,760,528	$ 7,042,111
	Yolo				$ 992,539	$ 992,539	$ 661,693	$ 2,646,771
	Yuba				$ 719,131	$ 719,131	$ 479,421	$ 1,917,684
	Local Lab: Kern/Kings/Madera/Merced				$ 3,112,500	$ 3,112,500	$ 2,075,000	$ 8,300,000
	A. Local-Level Contracts Subtotal				***$ 106,349,659***	***$ 107,250,000***	***$ 71,500,000***	***$ 285,099,659***
	B. State-Level Subcontracts							
	Media Contractor (CHC)				$ 1,250,000	$ 2,500,000	$ 1,250,000	$ 5,000,000
	RFA for Pilot Projects (OHE)				$ 1,250,000	$ 2,500,000	$ 1,250,000	$ 5,000,000
	UCSF Modeling Team Workload (CID)				$ 300,000	$ 500,000	$ 200,000	$ 1,000,000
	TBD - Whole Genome Sequencing Project				$ 2,000,000	$ 2,000,000	$ 1,000,000	$ 5,000,000
	TBD - Mobile Laboratory Testing Capacity to address testing disparities				$ 68,777,169	$ 18,000,000	$ 10,000,000	$ 96,777,169
	TBD - State Surveillance Activities Focus on Disparities and Vulnerable Populations				$ 3,000,000	$ 5,000,000	$ 2,000,000	$ 10,000,000
	B. State-Level Subcontracts Subtotal				***$ 76,577,169***	***$ 30,500,000***	***$ 15,700,000***	***$ 122,777,169***
	7. Subcontracts Subtotal				***$ 182,926,828***	***$ 137,750,000***	***$ 87,200,000***	***$ 407,876,828***
8.	**Indirect Costs (19.9%)**							
	CDPH Indirect Cost Rate is approved annually by the U.S. Department of Agriculture (USDA) for all public health programs and locations. The approved fixed rate of 19.9% consists of Departmental Overhead. Calculation is based off of total Personnel and Benefits.				$ 111,644	$ 127,617	$ 43,678	$ 282,939
	8. Indirect Costs Subtotal				***$ 111,644***	***$ 127,617***	***$ 43,678***	***$ 282,939***
	Total Budget				***$ 198,569,866***	***$ 166,919,279***	***$ 101,962,228***	***$ 467,451,373***

EXHIBIT C
TO THE STATE AGREEMENT

FLOW DOWN PROVISIONS-Notice of Award Attached

1. DATE ISSUED *MM/DD/YYYY* 05/18/2020

1a. SUPERSEDES AWARD NOTICE dated 05/05/2020 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

2. CFDA NO.
[redacted] - Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

[redacted]

3. ASSISTANCE TYPE Cooperative Agreement

4. GRANT NO. [redacted]
Formerly

5. TYPE OF AWARD
Demonstration

4a. FAIN [redacted]

5a. ACTION TYPE Post Award Amendment

6. PROJECT PERIOD *MM/DD/YYYY*
From 08/01/2019 Through *MM/DD/YYYY* 07/31/2024

7. BUDGET PERIOD *MM/DD/YYYY*
From 08/01/2019 Through *MM/DD/YYYY* 07/31/2020

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)
301(A)AND317(K)(2)PHS42USC241(A)247B(K)2

8. TITLE OF PROJECT (OR PROGRAM)
PHFE CDPH ELC 2019-2024

9a. GRANTEE NAME AND ADDRESS
Public Health Foundation Enterprises, Inc.
[redacted]

9b. GRANTEE PROJECT DIRECTOR
[redacted]

10a. GRANTEE AUTHORIZING OFFICIAL
[redacted]

10b. FEDERAL PROJECT OFFICER
[redacted]

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes Direct Assistance)

I Financial Assistance from the Federal Awarding Agency Only
II Total project costs including grant funds and all other financial participation — I

a.	Salaries and Wages	4,376,406.00
b.	Fringe Benefits	1,574,695.00
c.	Total Personnel Costs	5,951,101.00
d.	Equipment	262,000.00
e.	Supplies	1,532,769.00
f.	Travel	246,619.00
g.	Construction	0.00
h.	Other	541,606,799.00
i.	Contractual	1,571,792.00
j.	TOTAL DIRECT COSTS	551,171,080.00
k.	INDIRECT COSTS	1,150,907.00
l.	TOTAL APPROVED BUDGET	552,321,987.00
m.	Federal Share	552,321,987.00
n.	Non-Federal Share	0.00

12. AWARD COMPUTATION

a. Amount of Federal Financial Assistance (from item 11m)	552,321,987.00
b. Less Unobligated Balance From Prior Budget Periods	0.00
c. Less Cumulative Prior Award(s) This Budget Period	53,118,807.00
d. **AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION**	499,203,180.00
13. Total Federal Funds Awarded to Date for Project Period	552,321,987.00

14. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER *(See REMARKS)*

b

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARDING AGENCY ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation
b. The grant program regulations.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - ☒ Yes ☐ No)
ELC Enhancing Detection Funding: Financial Assistance in the amount of $499,203,180

GRANTS MANAGEMENT OFFICIAL:
[redacted]

17.OBJ CLASS 41.51	18a. VENDOR CODE [redacted]	18b. EIN [redacted]	19. DUNS [redacted]	20. CONG. DIST. 32
FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	APPROPRIATION
21. a. [redacted]	b. [redacted]	c. CK	d. $499,203,180.00	e. [redacted]
22. a.	b.	c.	d.	e.
23. a.	b.	c.	d.	e.

NOTICE OF AWARD (Continuation Sheet)

PAGE 2 of 3	DATE ISSUED 05/18/2020
GRANT NO. [redacted]	

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

NOTICE OF AWARD (Continuation Sheet)

PAGE 3 of 3	DATE ISSUED 05/18/2020
GRANT NO. [redacted]	

Federal Financial Report Cycle			
Reporting Period Start Date	Reporting Period End Date	Reporting Type	Reporting Period Due Date
08/01/2019	07/31/2020	Annual	10/29/2020

AWARD ATTACHMENTS

Public Health Foundation Enterprises, Inc. [redacted]

1. Terms and Conditions

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Non-research awards at https://www.cdc.gov/grants/federalregulationspolicies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number CK19-1904, entitled Epidemiology and Laboratory Capacity (ELC), which is hereby made a part of this Non-research award, hereinafter referred to as the Notice of Award (NoA).

Component Funding: Additional funding in the amount $499,203,180 is approved for the Year 01 budget period, which is August 1, 2019 through July 31, 2020

COVID-19 Paycheck Protection Program and Health Care Enhancement Act Response Activities:

E. Cross-Cutting Emerging Issues: $499,203,180

Recipients have **30 months** from the date of this NoA to expend all funds awarded herein

Budget/Workplan Revision Requirement: Within 30 days of this NoA, the recipient must submit a revised budget with a narrative justification outlining response activities. Failure to submit the required information in a timely manner may adversely affect the future funding of the project. If the information cannot be provided by the due date, you are required to contact your ELC Project Officer and Grant Management Specialist. The revised budget must be uploaded in GrantSolutions as an amendment to allow issuance of a revised NoA.

Pre-Award Costs: Pre-award costs dating back to January 20, 2020 – when CDC first activated its Emergency Operations Center (EOC) – and directly related to the COVID-19 outbreak response are allowable.

Indirect Costs: Indirect cost will be approved based on current approved negotiated indirect cost rate agreement.

Overtime: Because overtime costs are a very likely and reasonable expense during the response to COVID-19, CDC will allow recipients to include projected overtime in their budgets. Recipients should be careful to estimate costs based on current real-time needs and will still be required to follow federal rules and regulations in accounting for the employees' time and effort.

Additional Term and Condition:
A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the "CARES Act") (P.L. 116-136); and/or the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) agrees, as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health measures (e.g., social distancing, home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation.

In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS–CoV–2 or to diagnose a possible case of COVID–19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC.

Further, consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the

purpose of this award, and the underlying funding, the recipient is expected to provide to CDC copies of and/or access to COVID-19 data collected with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.

This award is contingent upon agreement by the recipient to comply with existing and future guidance from the HHS Secretary regarding control of the spread of COVID-19. In addition, recipient is expected to flow down these terms to any subaward, to the extent applicable to activities set out in such subaward.

Unallowable Costs:

- Research
- Clinical care
- Publicity and propaganda (lobbying):
    - Other than for normal and recognized executive-legislative relationships, no funds may be used for:
        - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
        - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
    - See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients: https://www.cdc.gov/grants/documents/Anti-Lobbying_Restrictions_for_CDC_Grantees_July_2012.pdf

- ***All unallowable costs cited in CDC-RFA-CK19-1904 remain in effect, unless specifically amended in this guidance, in accordance with 45 CFR Part 75 – Uniform Administrative Requirements, Cost Principles, And Audit Requirements for HHS Awards.***

REPORTING REQUIREMENTS

Additional Reporting:

- Monthly fiscal reports (beginning 60 days after NOAs are issued)
- Quarterly progress reports on status of timelines, goals, and objectives as defined by CDC in approved work plans
- Quarterly Performance measure data
- CDC may require recipients to develop annual progress reports (APRs). CDC will provide APR guidance and optional templates should they be required.
- Quarterly reporting of test results, both positive and negative
- Clarity on how the states will focus on high socially vulnerable index counties, rural and urban areas, etc. (Vulnerable populations must be specific).

Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the

following addresses:

CDC, Office of Grants Services
[redacted]

AND

U.S. Department of Health and Human Services Office of the Inspector General
ATTN: Mandatory Grant Disclosures, [redacted]

Fax: [redacted] (Include "Mandatory Grant Disclosures" in subject line) or Email: MandatoryGranteeDisclosures@oig.hhs.gov

Recipients must include this mandatory disclosure requirement in all subawards and contracts under this award.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

CDC is required to report any termination of a federal award prior to the end of the period of performance due to material failure to comply with the terms and conditions of this award in the OMB-designated integrity and performance system accessible through SAM (currently FAPIIS). (45 CFR 75.372(b)) CDC must also notify the recipient if the federal award is terminated for failure to comply with the federal statutes, regulations, or terms and conditions of the federal award. (45 CFR 75.373(b))

PAYMENT INFORMATION

The HHS Office of the Inspector General (OIG) maintains a toll-free number (1- 800-HHS- TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application.

The grant document number identified on the bottom of Page 1 of the Notice of Award must be known in order to draw down funds.

Stewardship: The recipient must exercise proper stewardship over Federal funds by ensuring that all costs charged to your cooperative agreement are allowable, allocable, and reasonable and that they address the highest priority needs as they relate to this program.

All the other terms and conditions issued with the original award remain in effect throughout the budget period unless otherwise changed, in writing, by the Grants Management Officer.

EXHIBIT D
TO THE STATE AGREEMENT

FORM OF INVOICE

Template to be determined after execution

Invoices must be submitted on a monthly basis as outlined in Sections 4 and 5 of this agreement.

The final invoice must be received by January 15, 2023.

ELC ENHANCING DETECTION INVOICE

[redacted]
Acting Director

GAVIN NEWSOM
Governor

California Department of Public Health
Emergency Preparedness Office

Date: August 18, 2020

CDPH Contract Number: [redacted]
Contract Term: 5/18/2020 - 11/17/2022
Billing Period: August 2020
CDPH Invoice Number: [redacted]

Name/Address (to send warrant):
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
[redacted]

Telephone: [redacted]

Budget Line Item	Expenditures This Period
Personnel	$ -
Equipment	$ -
Supplies	$ -
Travel	$ -
Other	$ -
Local Health Departments	$ 71,500,000.00
Subcontractors	$ -
Indirect	$ -
	$ 71,500,000.00

I certify that this claim is in all respects true, correct, supportable by available documentation, and in compliance with all terms/conditions, laws, and regulations governing its payment.

Melissa Relles, Assistant Deputy Director, EPO
Printed Name and Title of Authorized Representative
Signature and Date of Authorized Representative

Exhibit E
Information Privacy and Security Requirements
(For Non-HIPAA/HITECH Act Contracts)

This Mutual Information Privacy and Security Requirements Exhibit (For Non-HIPAA/HITECH Act Contracts) (hereinafter referred to as "this Exhibit") sets forth the information privacy and security requirements the Parties are obligated to follow with respect to all personal and confidential information (as defined herein) disclosed, or collected, created, maintained, stored, transmitted or used by each Party for or on **behalf** of the other Party, pursuant to the Agreement between HELUNA HEALTH and the State/CDPH (the "Agreement"). (Such personal and confidential information is referred to herein collectively as "PCI".) Each Party desires to protect the privacy and provide for the security of PCI pursuant to this Exhibit and in compliance with state and federal laws applicable to the PCI.

I. Order of Precedence: With respect to information privacy and security requirements for all PCI, the terms and conditions of this Exhibit shall take precedence over any conflicting terms or conditions set forth in any other part of the agreement between the Parties, including Exhibit A (Scope of Work), all other exhibits and any other attachments, and shall prevail over any such conflicting terms or conditions.

II. Effect on lower tier transactions: The terms of this Exhibit shall apply to all contracts, subcontracts, subawards, and to the information privacy and security requirements each Party is obligated to follow with respect to PCI disclosed, collected, created, maintained, stored, transmitted or used pursuant to the Agreement. When applicable the Parties shall incorporate the relevant provisions of this Exhibit into each subcontract or subaward to its agents, subcontractors, or independent consultants.

III. Definitions: For purposes of the Agreement, including this Exhibit, the following definitions shall apply:

A. Breach:

"Breach" means:

1. the unauthorized acquisition, access, use, or disclosure of PCI in a manner which compromises the security, confidentiality or integrity of the information; or

2. the same as the definition of "breach of the security of the system" set forth in California Civil Code section 1798.29(f).

B. Confidential Information: "Confidential information" means information that:

1. does not meet the definition of "public records" set forth in California Government Code section 6252(e), or is exempt from disclosure under any of the provisions of Section 6250, et seq. of the California Government Code or any other applicable state or federal laws; or

2. is contained in documents, files, folders, books or records that are clearly labeled, marked or designated with the word "confidential".

C. Disclosure: "Disclosure" means the release, transfer, provision of, access to, or divulging in any manner of information outside the entity holding the information.

D. PCI: "PCI" means "personal information" and "confidential information" (as these terms are defined herein:

Exhibit E
Information Privacy and Security Requirements
(For Non-HIPAA/HITECH Act Contracts)

E. Personal Information: "Personal information" means information, in any medium (paper, electronic, oral) that:

1. directly or indirectly collectively identifies or uniquely describes an individual; or

2. could be used in combination with other information to indirectly identify or uniquely describe an individual, or link an individual to the other information; or

3. meets the definition of "personal information" set forth in California Civil Code section 1798.3, subdivision (a) or

4. is one of the data elements set forth in California Civil Code section 1798.29, subdivision (g)(1) or (g)(2); or

5. meets the definition of "medical information" set forth in either California Civil Code section 1798.29, subdivision (h)(2) or California Civil Code section 56.05, subdivision (j); or

6. meets the definition of "health insurance information" set forth in California Civil Code section 1798.29, subdivision (h)(3); or

7. is protected from disclosure under applicable state or federal law.

F. Security Incident: "Security Incident" means:

1. an attempted breach; or

2. the attempted or successful unauthorized access or disclosure, modification or destruction of PCI, in violation of any state or federal law or in a manner not permitted under the Agreement including this Exhibit; or

3. the attempted or successful modification or destruction of, or interference with system operations in an information technology system, that negatively impacts the confidentiality, availability or integrity of PCI; or

4. any event that is reasonably believed to have compromised the confidentiality, integrity, or availability of an information asset, system, process, data storage, or transmission. Furthermore, an information security incident may also include an event that constitutes a violation or imminent threat of violation of information security policies or procedures, including acceptable use policies.

G. Use: "Use" means the sharing, employment, application, utilization, examination, or analysis of information.

IV. Disclosure Restrictions: Each Party and its employees, agents, and subcontractors shall protect from unauthorized disclosure any PCI. Each Party shall not disclose, except as otherwise specifically permitted by the Agreement (including this Exhibit), any PCI to anyone other than authorized personnel or programs without prior written authorization from either Party, except if disclosure is required by State or Federal law or necessary to perform under the Agreement.

Exhibit E
Information Privacy and Security Requirements
(For Non-HIPAA/HITECH Act Contracts)

V. Use Restrictions: Each Party and its employees, agents, and subcontractors shall not use any PCI for any purpose other than performing their obligations under the Agreement.

VI. Safeguards: Each Party shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the privacy, confidentiality, security, integrity, and availability of PCI, including electronic or computerized PCI. At each location wher PCI exists each Party shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of operations and the nature and scope of its activities in satisfying the Agreement, including this Exhibit, and which incorporates the requirements of Section VII, Security, below. Each Party shall provide current and updated policies within five (5) business days of a written request by the other.

VII. Security: Each Party shall take any and all steps reasonably necessary to ensure the continuous security of all computerized data systems containing PCI. These steps shall include, at a minimum, complying with all of the data system security precautions listed in the Data Security Standards set forth in Attachment 1 to this Exhibit.

VIII. Security Officer: At places where PCI is located, a Security Officer shall oversee its compliance with this Exhibit and shall communicate on matters concerning this Exhibit.

IX. Training: Each Party shall provide training on its obligations under this Exhibit, at its own expense, to all of its employees who assist in the performance of The Agreement, including this Exhibit, or otherwise use or disclose PCI.

A. Each Party shall require employees who receive training to certify, either in hard copy or electronic form, the date on which the training was completed.

B. Each Party shall retain employee certifications for inspection for a period of three years following contract termination or completion.

C. Each Party shall provide the other with its employee certifications within five (5) business days of a witten request.

X. Employee Discipline: Each Party shall impose discipline that it deems appropriate (in its sole discretion) on such employees and other workforce members under their direct control who intentionally or negligently violate any provisions of this Exhibit.

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XI. Breach and Security Incident Responsibilities:

A. Notification of Breach or Security Incident: Each Party shall notify the other **immediately by telephone call plus email or fax** upon the discovery of a breach (as defined in this Exhibit), **and** within **seventy-two (72) hours by email or fax** of the discovery of any security incident (as defined in this Exhibit), unless a law enforcement agency determines that the notification will impede a criminal investigation, in which case the notification required by this section shall be made immediately after the law enforcement agency determines that such notification will not compromise the investigation. Notification shall be provided to, as applicable, the Program Contract Manager, the Privacy Officer and the Chief Information Security Officer, using the contact information listed in Section XI(F), below. If the breach or security incident is discovered after business hours or on a weekend or holiday and involves PCI in electronic or computerized form, notification shall be provided by calling the Information Security Office at the telephone numberslisted in Section XI(F), below. For purposes of this Section, breaches and security incidents shall be treated as discovered as of the first day on which such breach or security incident is known, or, by exercising reasonable diligence would have been known.

Each Party shall take:

1. prompt corrective action to mitigate any risks or damages involved with the breach or security incident and to protect the operating environment; and

2. any action pertaining to a breach required by applicable federal and state laws, including, specifically, California Civil Code section 1798.29.

B. Investigation of Breach and Security Incidents: Each Party shall immediately investigate such breach or security incident. As soon as the information is known and subject to the legitimate needs of law enforcement, then the responsible party shall inform, as applicable the other Party's Program Contract Manager, the Privacy Officer, and the Chief Information Security Officer of:

1. what data elements were involved and the extent of the data disclosure or access involved in the breach, including, specifically, the number of individuals whose personal information was breached; and

2. a description of the unauthorized persons known or reasonably believed to have improperly used the PCI and/or a description of the unauthorized persons known or reasonably believed to have improperly accessed or acquired the PCI, or to whom it is known or reasonably believed to have had the PCI improperly disclosed to them; and

3. a description of where the PCI is believed to have been improperly used or disclosed; and

4. a description of the probable and proximate causes of the breach or security incident; and

5. whether Civil Code section 1798.29 or any other federal or state laws requiring individual notifications of breaches have been triggered.

C. Written Report: Each Party shall provide a written report of the investigation to the other Party's Program Contract Manager, the Privacy Officer, and the Chief Information Security Officer or the equivalent, as soon as practicable after the discovery of the breach or security incident. The

report shall include, but not be limited to, the information specified above, as well as a complete, detailed corrective action plan, including information on measures that were taken to halt and/or contain the breach or security incident, and measures to be taken to prevent the recurrence or further disclosure of data regarding such breach or security incident.

D. Notification to Individuals: If notification to individuals whose information was breached is required under state or federal law, and regardless of whether the breaching Party is considered only a custodian and/or non-owner of the PCI, the breaching Party shall, at its sole expense, either:

1. make notification to the individuals affected by the breach (including substitute notification), pursuant to the content and timeliness provisions of such applicable state or federal breach notice laws, and inform the other Party's Privacy Officer or equivalent of the time, manner and content of any such notifications, prior to the transmission of such notifications to the individuals; or

2. cooperate with and assist the other Party in its notification (including substitute notification) to the individuals affected by the breach.

E. Submission of Sample Notification to Attorney General: If notification to more than 500 individuals is required pursuant to California Civil Code section 1798.29, and regardless of whether the breaching Party is considered only a custodian and/or non-owner of the PCI, the breaching Party shall, at its sole expense, either:

1. electronically submit a single sample copy of the security breach notification, excluding any personally identifiable information, to the Attorney General pursuant to the format, content, and timeliness provisions of Section 1798.29, subdivision (e). The breaching Party shall inform the other Party's Privacy Officer or equivalent of the time, manner and content of any such submissions, prior to the transmission of such submissions to the Attorney General; or

2. cooperate with and assist the other Party in its submission of a sample copy of the notification to the Attorney General.

F. CDPH Contact Information: To direct communications to the above referenced CDPH staff, HELUNA HEALTH shall initiate contact as indicated herein. CDPH reserves the right to make changes to the contact information below by written notice to HELUNA HEALTH. Said changes shall not require an amendment to this Exhibit or the agreement to which it is incorporated.

CDPH Program Contract Manager	**CDPH Privacy Officer**	**CDPH Chief Information Security Officer**
See the Scope of Work exhibit A for Program Contract Manager	Privacy Officer Privacy Office [redacted]	Chief Information Security Officer [redacted]

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	Email: privacy@cdph.ca.gov Telephone: [redacted]	Email: [redacted]@cdph.ca.gov Telephone: [redacted]

XII. HELUNA HEALTH Contact Information:

XIII. Documentation of Disclosures for Requests for Accounting: Each Party shall document and make available to the other Party or to an Individual such disclosures of PCI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of personal information as required by Civil Code section 1798.25, or any applicable state or federal law.

XIV. Requests for PCI by Third Parties: Each Party and its employees, agents, or subcontractors shall promptly transmit to the other Party's Program Contract Manager or equivalent all requests for disclosure of any PCI requested by third parties to the Agreement (except from an Individual for an accounting of disclosures of the individual's personal information pursuant to applicable state or federal law), unless prohibited from doing so by applicable state or federal law.

XV. Audits, Inspection and Enforcement: Either Party may inspect the facilities, systems, books and records of the other to monitor compliance with this Exhibit. The Parties shall promptly remedy any violation of any provision of this Exhibit and shall certify the same to their respective Contract Managers or equivalent in writing.

XVI. Return or Destruction of PCI on Expiration or Termination: Upon expiration or termination of the agreement between the Parties for any reason, each Party shall securely return or destroy the PCI received from, or on behalf of, the other Party. Personal Information accessed, used, or disclosed in performance of obligations under the Funding Award Agreement, including patient medical information and health insurance information, shall remain the exclusive property of CDPH. If return or destruction is not feasible, the Parties shall provide a written explanation to the appropriate authorities. (Program Contract Manager, the Privacy Officer and the Chief Information Security Officer, using the contact information listed in Section XI(F), and/or XII, above.)

A. Retention Required by Law: If required by state or federal law, the Parties may retain, after expiration or termination, PCI for the time specified as necessary to comply with the law.

B. Obligations Continue Until Return or Destruction: Each Party's obligations under this Exhibit shall continue until they return or destroy the PCI provided however, that on expiration or termination of the Agreement ,neither Party shall use or disclose the PCI except as required by state or federal law.

C. Notification of Election to Destroy PCI: If either Party elects to destroy the PCI, then they shall certify in writing, to the following authorities or their equivalent: Contract Manager, the Privacy Officer and the Chief Information Security Officer, using the contact information listed in Section XI(F), and/or XII, above, that the PCI has been securely destroyed. The notice shall include the date and type of destruction method used.

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XVII. Amendment: The Parties acknowledge that federal and state laws regarding information security and privacy rapidly evolves and that amendment of this Exhibit may be required to provide for procedures to ensure compliance with such laws. The parties specifically agree to take such action as is necessary to implement new standards and requirements imposed by regulations and other applicable laws relating to the security or privacy of PCI.The parties agree to promptly enter into negotiations concerning an amendment to this Exhibit consistent with new standards and requirements imposed by applicable laws and regulations.

XVIII. Assistance in Litigation or Administrative Proceedings: Each Party shall make itself and any subcontractors, workforce employees or agents assisting in the performance of its obligations under the Agreement available at no cost to testify as witnesses, in the event of litigation or administrative proceedings being commenced against the other Party, its director, officers or employees based upon claimed violation of laws relating to security and privacy, which involves inactions or actions, except where such Party or its subcontractors, workforce employee or agent is a named adverse party.

XIX. No Third-Party Beneficiaries: Nothing express or implied in the terms and conditions of this Exhibit is intended to confer, nor shall anything herein confer, upon any person other than CDPH or HELUNA HEALTH and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

XX. Interpretation: The terms and conditions in this Exhibit shall be interpreted as broadly as necessary to implement and comply with regulations and applicable State laws. The parties agree that any ambiguity in the terms and conditions of this Exhibit shall be resolved in favor of a meaning that complies and is consistent with federal and state laws and regulations.

XXI. Survival: If either Party does not return or destroy the PCI upon the completion or termination of the Agreement, their respective rights and obligations under Sections VI, VII and XI of this Exhibit shall survive the completion or termination of the agreement.

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Attachment 1
Each Party Data Security Standards

1. General Security Controls

A. ***Confidentiality Statement.*** All persons that will be working with PCI must sign a confidentiality statement. The statement must include at a minimum, General Use, Security and Privacy safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to PCI. The statement must be renewed annually. Each Party shall retain each person's written confidentiality statement for inspection for a period of three (3) years following contract termination.

B. ***Workforce Member Assessment.*** Before a member of either Party's workforce may access PCI, each Party must ensure that all workforce members that will have access to PCI have been assessed to assure that there is no indication that the workforce member may present a risk to the security or integrity of PCI. Each Party shall retain each workforce member's assessment documentation, whether in physical or electronic format, for a period of three (3) years following contract termination.

C. ***Workstation/Laptop encryption.*** All workstations and laptops that process and/or store PCI must be encrypted using a FIPS 140-2 certified algorithm, such as Advanced Encryption Standard (AES), with a 128bit key or higher. The encryption solution must be full disk unless approved by the the other Party's Information Security Office.

D. ***Server Security.*** Servers containing unencrypted PCI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

E. ***Minimum Necessary.*** Only the minimum necessary amount of PCI required to perform necessary business functions may be copied, downloaded, or exported.

F. ***Removable media devices.*** All electronic files that contain PCI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smart devices tapes etc.). PCI must be encrypted using a FIPS 140-2 certified algorithm, such as Advanced Encryption Standard (AES), with a 128bit key or higher

G. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store PCI must install and actively use a comprehensive anti-virus software solution with automatic updates scheduled at least daily.

H. ***Patch Management.*** All workstations, laptops and other systems that process and/or store PCI must have operating system and application security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

I. ***User IDs and Password Controls.*** All users must be issued a unique user name for accessing PCI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password. Passwords

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are not to be shared. Must be at least eight characters. Must be a non-dictionary word. Must not be stored in readable format on the computer. Must be changed every 60 days. Must be changed if revealed or compromised. Must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

J. ***Data Sanitization.*** All PCI must be sanitized using NIST Special Publication 800-88 standard methods for data sanitization when the PCI is no longer needed.

2. System Security Controls

A. ***System Timeout.*** The system must provide an automatic timeout, requiring reauthentication of the user session after no more than 20 minutes of inactivity.

B. ***Warning Banners.*** All systems containing PCI must display a warning banner each time a user attempts access, stating that data is confidential, systems are logged, and system use is for business purposes only. User must be directed to log off the system if they do not agree with these requirements.

C. ***System Logging.*** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for PCI, or which alters PCI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. This logging must be included for all user privilege levels including, but not limited to, systems administrators. If PCI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

D. ***Access Controls.*** The system must use role based access controls for all user authentications, enforcing the principle of least privilege.

E. ***Transmission encryption.*** All data transmissions of PCI outside either Party's secure internal network must be encrypted using a FIPS 140-2 certified algorithm, such as Advanced Encryption Standard (AES), with a 128bit key or higher. Encryption can be end to end at the network level, or the data files containing PCI can be encrypted. This requirement pertains to any type of PCI in motion such as website access, file transfer, and E-Mail.

F. ***Intrusion Detection***. All systems involved in accessing, holding, transporting, and protecting PCI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

3. Audit Controls

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A. ***System Security Review.*** All systems processing and/or storing PCI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews shall include vulnerability scanning tools.

B. ***Log Reviews.*** All systems processing and/or storing PCI must have a routine procedure in place to review system logs for unauthorized access.

C. ***Change Control.*** All systems processing and/or storing PCI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

4. Business Continuity / Disaster Recovery Controls

A. ***Disaster Recovery.*** Each Party must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic PCI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this agreement for more than 24 hours.

B. ***Data Backup Plan.*** Each Party must have established documented procedures to securely backup PCI to maintain retrievable exact copies of PCI. The backups shall be encrypted.The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and the amount of time to restore PCI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of data.

5. Paper Document Controls

A. ***Supervision of Data.*** PCI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. PCI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. ***Escorting Visitors.*** Visitors to areas where PCI is contained shall be escorted and PCI shall be kept out of sight while visitors are in the area.

C. ***Confidential Destruction.*** PCI must be disposed of through confidential means, using NIST Special Publication 800-88 standard methods for data sanitization when the PCI is no longer needed.

D. ***Removal of Data.*** PCI must not be removed from the environments, systems, or equipment that the recipient of such PCI controls, except with express written permission of the other party.

E.

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F. ***Faxing.*** Faxes containing PCI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending.

G. ***Mailing.*** PCI shall only be mailed using secure methods. Large volume mailings PCI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted with a approved solution, such as a solution using a vendor product specified on the CALIFORNIA STRATEGIC SOURCING INITIATIVE.

Exhibit F

State of California—Health and Human Services Agency
California Department of Public Health

[redacted]
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Bona Fide Agent Designation

Between

California Department of Public Health ("CDPH")

[redacted]

and

Public Health Foundation Enterprises, Inc. ("PHFE")

[redacted]

I. CDPH hereby designates PHFE as its Bona Fide Agent to submit a grant application and administer any resulting award(s) under the State of California's eligibility in lieu of a State application for the federal Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC) funding opportunity:

Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Cooperative Agreement - Building and Strengthening Epidemiology, Laboratory and Health Information Systems Capacity in State and Local Health Departments.

The purpose of the ELC Cooperative Agreement is to protect the public health and safety of the American people by enhancing the capacity of public health agencies to effectively detect, respond, prevent and control known and emerging (or re-emerging) infectious diseases. Capacity is defined as the ability to conduct work; a stronger infrastructure leads to increased capacity. This is accomplished by providing financial and technical resources to (1) strengthen epidemiologic capacity; (2) enhance laboratory capacity; (3) improve information systems; and (4) enhance collaboration among epidemiology, laboratory, and information systems

components of public health departments. State ELC programs must establish and maintain general, cross-cutting functions and structures to successfully conduct the programmatic activities outlined in the FOA. These include supporting disease surveillance, data analysis, data management, disease control, and laboratory testing activities.

II. This Designation shall be in effect from October 1, 2024 through September 30, 2029 in order to accommodate for grant closeout, or until the ELC Cooperative Agreement terminates, whichever date is earlier.

III. PHFE shall be responsible for the ELC Cooperative Agreement and assuring compliance with agreement requirements including, but not limited to, implementation of strategies and activities, progress and financial reporting requirements, grant application, administration of any and all ELC Cooperative Agreement requirements pursuant to the Funding Opportunity Announcement (FOA) mandates for all years this bona fide agency agreement is in effect, and any and all additional applicable requirements.

IV. CDPH shall be responsible for submitting timely (within 30 days) backup documentation to PHFE for all costs expended (including costs incurred by local health jurisdictions) for use of grant funding that align with all ELC Cooperative Agreement requirements. Documentation requirements shall be (i) further defined in a subaward agreement between the parties and (ii) crafted to enable PHFE to substantiate all costs claimed for reimbursement. CDPH shall be responsible for repayment of any of its reimbursed costs that are deemed not to be allocable, allowable or reasonable in amount.

V. PHFE shall be responsible for timely payments to CDPH within 30 calendar days of receipt of an invoice that includes adequate supporting documentation as noted in Section IV above. In the event that any portion of the invoice does not have adequate documentation, PHFE shall pay the claim for all sub-invoices for vendors/LHJs who had the required documentation and provide a listing of those sub-invoices for vendors/LHJs that were not paid. CDPH will resubmit its invoice with required documentation for all vendors/LHJ claims not paid.

VI. PHFE and CDPH will meet at a minimum monthly at the staff level and at least quarterly at a leadership level to resolve any issues related to program activities or expenditures/payment.

VII. CDPH is authorized under Division 105 (commencing with section 120100) of the Health & Safety Code to examine the causes of communicable disease.

VIII. PHFE is fully authorized to perform the administrative tasks necessary to obtain and implement the ELC Cooperative Agreement, including but not limited to:

1. Apply for and process the ELC Cooperative Agreement;
2. Provide overall coordination of Agreement implementation in collaboration with CDPH;
3. Provide general administrative functions and support of the grant;
4. Recruit, hire, and manage human resources activities for ELC program staff;
5: Audit the ELC budget and expenditures;
6. Prepare reports to CDC as required by the ELC Program, Cooperative Agreement mandates and/or CDPH;
7. Assist CDPH in the preparation of Legislative and data summary reports;
8. Act as an agent to CDC;
9. Adhere to all administrative requirements outlined in 45 Code of Federal Regulations (CFR) 2 Part 215 or Part 92, as appropriate, including
    - AR-8 Public Health System Reporting Requirements
    - AR-9 Paperwork Reduction Act Requirements
    - AR-10 Smoke-Free Workplace Requirements
    - AR-11 Healthy People 2020
    - AR-12 Lobbying Restrictions
    - AR-14 Accounting System Requirements
    - AR-21 Small, Minority, and Women-Owned Business
    - AR-24 Health Insurance Portability and Accountability Act Requirements
    - AR-25 Release and Sharing of Data
    - AR-27 Conference Disclaimer and Use of Logos
    - AR-29 Compliance with E.O. 13513 Federal Leadership on Reducing
    - Text Messaging while Driving, October 1, 2009

IX. The ELC infrastructure depends on a direct relationship with public health agencies that have sufficient legal authority and responsibility to perform public health surveillance and response activities. PHFE shall collaborate with CDPH.

X. PHFE and its employees, officers, subcontractors, and agents shall act in an independent capacity and not as officers or employees of CDPH. PHFE shall have no authority to act on behalf of the Department in any way not specified in this Designation.

XI. CDPH employees may serve in the capacity of Principal Investigator (PI) as well as act as a member of the ELC steering committee to lend scientific and strategic guidance to projects conducted by the ELC program as requested by PHFE.

XII. INDEMNIFICATION: To the extent permitted under applicable law, PHFE agrees to indemnify, defend and save harmless the State, its officers, agents and employees

from any and all claims, demands, losses, causes of action, damage, lawsuits, judgments, including attorneys' fees and costs arising out of or relating to the work of any and all PHFE employees, subcontractors, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of the ELC programs and activities, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by PHFE in the performance of the ELC Cooperative Agreement.

XIII. PHFE accepts the Bona Fide Agent Designation and will comply with the terms of the ELC Cooperative Agreement, and the conditions set forth herein.

XIV. Authorized Signatures:

[redacted] 9/17/24
[redacted] Date
Public Health Foundation Enterprises, Inc.

[redacted] 09/05/24
[redacted] Date
California Department of Public Health

Exhibit G

Updated Companion Clarifying Document for ELC Enhancing Detection (ED) and Enhancing Detection Expansion (EDE) COVID-19 Funding

While ELC ED/EDE funds are already budgeted at the recipient level, below are things to consider as needs evolve. Please remember that all budget items must clearly link to an approved work plan. Please also note that unless a waiver from the Office of Financial Services (OFR) is obtained, ED/EDE funds are legislatively tied to COVID-19 and COVID-19 must be a part of the approved activities. Finally, these funds are not intended to duplicate support being provided through other forms of financial assistance. Please ensure there is ample coordination with Project Directors over grants and cooperative agreements that may have complementary work (i.e., PHEP and Crisis, Immunization, PHIG, etc.)

Clarification of Allowable Activities for the ED/EDE funds

As SARS-CoV-2/COVID-19 testing, surveillance, monitoring, and reporting becomes more integrated into the routine activities for respiratory pathogens more broadly, COVID-19 funded activities should still focus on directly benefiting COVID-19-related public health activities and improved situational awareness that may inform public health action. COVID-19-funded infrastructure and activities may integrate other pathogens and syndromes as long as COVID-19 testing or surveillance is included in the effort. For example, COVID funded laboratory, surveillance, epidemiology, and informatics personnel may work on other pathogens and syndromes, in addition to SARS-CoV-2 and COVID-19, as long as detection/assessment/reporting/visualization activities for SARS-CoV-2 and COVID-19 are included in their routine scope of work. Activities can be conducted and integrated within **broader respiratory pathogen program activities.** Examples of broad-scale work that may be appropriate to support with ED/EDE funds include (not exhaustive):

- **testing for SARS-CoV-2** alone or as part of a multi-pathogen panel
- **sequencing of SARS-CoV-2** positive specimens
- conducting sentinel or systematic respiratory pathogen focused **surveillance activities** (either laboratory based or syndrome-based approaches using case definitions of Influenza-like illness (ILI), COVID-like illness (CLI), acute respiratory illness (ARI), mortality, post-COVID conditions, and multisystem inflammatory syndrome in children (MIS-C)), including data management, analysis, visualization, and reporting
- **outbreak response** activities for respiratory illness in congregate settings that may be COVID-19-associated
- If not already supported through other awards, improving the completeness and accuracy of **immunization registries** (including for COVID-19 vaccines), or interoperability with the state's surveillance system
- Maintenance, support, and continued enhancement of **electronic integrated disease surveillance systems, public health laboratory information management system(s) (LIMS), electronic data exchange of core public health data** (e.g., electronic laboratory reports (ELR), electronic case reports (eCR), syndromic surveillance, electronic test orders and results (ETOR)), and other peripheral systems (e.g., integration engines, vocabulary services) used for the surveillance of COVID-19 and other pathogens.
- Maintenance, support, and continued enhancement of **modernized enterprise infrastructure and shared services** to ensure access to systems and data for public health action (e.g., data lakes/warehouses, master patient indices, data linkage tools, geospatial analysis)
- Development and support for internal and external **dashboards, reporting enhancements, and data modernization** that include COVID-19 data

Considerations for Utilization of Funds:

Below are items to consider that may support your approved work plans:

- Purchasing freezers, extraction equipment, testing and sequencing platforms, and other laboratory equipment, supplies, and reagents to support testing for SARS-CoV-2.
- Support for staffing with expertise in IT, data management, data visualization, communications, surveillance, epidemiology, statistical analyses, and informatics related respiratory illness and including COVID-19 and SARS-CoV-2.
- Costs related to maintenance and operations or licensing of integrated disease surveillance system or LIMS used for COVID-19 and other pathogens, including associated trainings for system administration and configuration.
- Preventative maintenance (PM) costs of already existing equipment/instruments that may be used for COVID testing. This is especially important for those assays covered under CLIA. Please remember that maintenance contracts may be set up with the manufacturer beyond warranty period for newly purchased equipment.
- Support for staffing or tools necessary for Quality Management Systems important for laboratory operations that carry out testing for SARS-CoV-2 and other respiratory pathogens.
- Enhancement of COVID and other respiratory pathogen surveillance activities and reporting.
- Regarding flexibilities related to contractual activities, consult with your jurisdiction acquisition office to learn more about your jurisdiction-specific policies. This will also require negotiation with the intended vendor.
    - Note: Service agreements that are paid up-front and have no additional costs associated at a later date can have timeframes that exceed the no-cost extension period of the ED/EDE ELC cooperative agreement period of performance which is currently July 31, 2026.

No Longer Supported

New **incentive requests**, new requests to **purchase vehicles**, **furniture,** and new requests for **construction** will no longer be supported. The allowance of these purchases was uniquely given during the pandemic, but they are not allowed under routine operations. This applies to recipients and subrecipients (e.g., LHDs).

Exhibit H

ELC PERFORMANCE MEASURES GUIDANCE FOR PROJECT E: ENHANCING DETECTION

CDC-[redacted]

CDC EPIDEMIOLOGY AND LABORATORY CAPACITY FOR PREVENTION AND CONTROL OF EMERGING INFECTIOUS DISEASES

June 2020

Contents

Introduction and Purpose

The goal of the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) is to support state, local, and territories' public health efforts to reduce morbidity and associated deaths caused by a wide range of infectious disease threats. The ELC provides annual funding, strategic direction and technical assistance to domestic jurisdictions for strengthening core capacities in epidemiology, laboratory, and health information systems activities. In addition to strengthening core infectious disease capacities nationwide, this cooperative agreement also supports a myriad of specific infectious disease programs and projects, and provides special appropriations in response to infectious disease emergencies (e.g., H1N1, Ebola, and Zika).

As part of the "Paycheck Protection Program and Health Care Enhancement Act of 2020 (P.L. 116-139, Title I)", the ELC awarded a total of $10.25 billion to our recipient base in a program-initiated component funding under the Emerging Issues (E) Project of CK19-1904, "ELC Enhancing Detection" supplement. These funds are broadly intended to provide critical resources to state, local, and territorial health departments in support of a broad range of COVID-19/SARS-CoV-2 testing and epidemiologic surveillance related activities, including the establishment of modernized public health surveillance systems. The work supported by ELC Enhancing Detection expands upon previous COVID-19 awards (ELC CARES and ELC Community-based Surveillance). These funds will support the public health response to COVID-19 and lay the foundation for the future of public health surveillance.

This guidance provides information on performance measures for recipients of these supplemental funds. To reduce reporting burden on recipients, the performance measures for ELC Enhancing Detection will encompass work being conducted for those receiving funds for ELC CARES and Community-based Surveillance.

The performance measures are intended to be used by ELC and recipients to help:

- Support continuous monitoring and examine opportunities to improve performance and implementation of activities;
- Demonstrate accountability to stakeholders (e.g., funders, public) by showing how ELC funds are being spent; and
- Clarify ELC project expectations and priorities.

The ELC realizes that there are limitations to using performance measures to evaluate the scope of public health work being conducted by the jurisdictions. For example, without a consideration of contextual factors, measures do not always fully represent how strongly or poorly a recipient is doing. Thus, it is important to have other ways of collecting project information to more fully demonstrate performance (i.e., workplan/milestone updates, progress calls, success stories). The ELC will rely on a combination of these sources of information in order to more fully assess progress throughout the duration of the project.

Organization of Guidance

For each measure, the following elements are described:

- *Measure:* Name of measure
- *Applicable recipients:* Recipients the measure applies to
- *Rationale:* Provides the context and reasoning for monitoring this measure
- *Data elements:* Specific variables that will be reported by recipient or monitored by ELC
- *Additional guidance:* Additional information to help understand the measure such as definitions for specific terms, inclusion/exclusion criteria, limitations to the measure, and other applicable information
- *Target:* Recommended recipient target for this measure, where applicable. Targets are used to provide guidance to recipients on the desired level of performance from ELC. They will also be used in discussions between ELC and recipients to identify gaps and opportunities to provide technical assistance.
- *Recommended data source:* Source the recipient or ELC may use to retrieve data
- *Reporting frequency:* Specifies how often the measure will be reported
- *Reporting mechanism:* Describes how data will be reported

Intended Use of Guidance

Please take some time to review the guidance and share it with the appropriate staff members in your jurisdiction who are involved in the implementation of these activities. Ensure that you and your staff members understand each measure and how it applies to your jurisdiction. Some of these measures will be monitored through data reporting from states already coming to CDC. ELC recommends that you develop a plan for how you will collect, organize, and synthesize this information for reporting.

While ELC has made every effort to consolidate reporting intervals, please note that some measures require more frequent reporting than others. Furthermore, due to the relatively long (30 month) project period, recipients should anticipate and work with ELC to re-evaluate and potentially modify some measures due to shifts in priorities during the time frame of this project and efforts to improve the ability to monitor performance and progress. Some additional data collection for other measures may be required, and some measures may eventually become obsolete. ELC will make every effort to keep these changes minimal.

If you have questions related to these performance measures, please contact [redacted]@cdc.gov, or your ELC Project Officer.

List of Performance Measures At-A-Glance

Measure E.1	Median number of days from specimen collection date to date of report of final test result for COVID-19/SARS-CoV-2 molecular diagnostic tests
Measure E.2	Number of COVID-19/SARS-CoV-2 tests completed by test type and result
Measure E.3	Proportion of COVID-19/SARS-CoV-2 lab reports with complete information
Measure E.4	Proportion of COVID-19/SARS-CoV-2 testing sites that received biosafety guidance and conducted laboratory risk assessments
Measure E.5	Proportion of COVID-19 cases submitted to CDC that include key data elements
Measure E.6	Proportion of COVID-19 cases with individual-level data submitted to CDC
Measure E.7	Median number of days from date of first positive specimen collection (or when not available, diagnosis date) to date COVID-19 case is reported to CDC
Measure E.8	Proportion of emergency department (ED) visits in the jurisdiction that are used for syndromic surveillance and shared with National Syndromic Surveillance Program (NSSP)
Measure E.9	Completeness of priority data elements in ED visits reported to NSSP
Measure E.10	Total number of patient visits reported each week by regularly reporting ILINet sites
Measure E.11	Proportion of specimen testing results for all respiratory viruses tested at the public health laboratory that are submitted to CDC via PHLIP 2.5.1 with valid data for all key variables
Measure E.12	Number of healthcare organizations engaged to implement electronic case reporting (eCR)
Measure E.13	Proportion of state reportable disease cases with an electronic initial case report (eICR) submitted
Measure E.14	Demonstration of automatic processing of electronic initial case reports (eICRs) in the jurisdiction integrated surveillance system(s)
Measure E.15	Proportion of test orders and results processed through Electronic Test Orders and Results (ETOR) at the PHL
Measure E.16	Systems/programs at the PHL with ETOR interfaces
Measure E.17	Number of cases assigned, per case investigator
Measure E.18	Number of contacts assigned, per contact tracer
Measure E.19	Among cases prioritized for case investigation, proportion interviewed within 24 hours of case report to the case investigation unit
Measure E.20	Among close contacts identified by cases interviewed, proportion notified within 24 hours of initiation for follow-up
Measure E.21	Among contacts notified, proportion tested for COVID-19 at least once, within 14 days of notification
Measure E.22	Number of new confirmed or probable COVID-19 cases identified among contacts in the contact tracing system, within 14 days of last exposure to the index case
Measure E.23	Number of health department staff who can perform healthcare infection control assessments at state and local level
Measure E.24	Number of healthcare infection control assessment and response (ICAR) conducted by the health department or designee for COVID-19, by method, setting, type (reactive or proactive), and entity that completed the assessment
Measure E.25	Number of COVID-19 outbreaks and responses in healthcare settings

Measure E.1: Median number of days from specimen collection date to date of report of final test result for COVID-19/SARS-CoV-2 molecular diagnostic tests

Applicable Recipients	All states, NYC, DC, Philadelphia, Houston, Los Angeles County, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, Palau, Puerto Rico, and US Virgin Islands
Rationale	Laboratory turnaround time can impact public health's ability to respond to events in a timely manner. Whether or not tests are being conducted in a timely manner may help identify areas for improvement or point to gaps in the process to help achieve more timely detection and reduce the spread of COVID-19. Public health may have limited control over tests conducted by non-PHL laboratories/community testing sites and the quality of specimens sent to public health. However, since the majority of COVID-19/SARS-CoV-2 testing is performed outside of the PHL, assessing all laboratories ability to perform timely testing and reporting is a critical component in the success of our public health response. These data will be used to guide discussions between ELC and the recipient on how to work together to improve testing timeliness, where needed.
Data Elements	For the PHL: 1. Median number of days and range from specimen collection date to receipt of specimen at the laboratory for COVID-19/SARS-CoV-2 molecular tests conducted in the PHL 2. Median number of days and range from receipt of specimen to date of report of final test result for COVID-19/SARS-CoV-2 molecular tests conducted in the PHL For non-PHL laboratories/community testing sites: 3. Median number of days and range from specimen collection date to date of report of final test result for COVID-19/SARS-CoV-2 molecular tests conducted outside of the PHL
Additional Guidance	This measure applies to molecular tests conducted covering your entire jurisdiction. If the date of report of final test result is missing, we will use the date the test result was determined. The median number of days and range should include weekend days. *Specimen collection to receipt of specimen:* This includes the time from collection of specimen to receipt of the specimen in the laboratory. *Receipt of specimen to final test result:* This includes the time from receipt of specimen, obtaining laboratory test results, and then reporting the result to public health.
Target	≤ 2-day from specimen collection to receipt of specimen. ≤ 2-day from receipt of specimen to date of report of final test result.
Recommended Data Source	LIMS
Reporting Frequency	Quarterly

Reporting Mechanism	☒ REDCap for PHLs ☒ CDC currently has this data for non-PHL laboratories/community testing sites and there is no need to report it at this time.

Measure E.2: Number of COVID-19/SARS-CoV-2 tests completed by test type and result

Applicable Recipients	All states, NYC, DC, Philadelphia, Houston, Los Angeles County, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, Palau, Puerto Rico, and US Virgin Islands
Rationale	A major purpose of this funding is to ensure a robust testing program for COVID-19/SARS-CoV-2 is in place. Recipients are expected to expand testing capacity, including working with non-PHL laboratories/community testing sites, to enable the jurisdiction to test sufficient numbers of its population in accordance with CDC guidelines and in alignment with a jurisdiction's testing plan. This measure looks at the volume of COVID-19/SARS-CoV-2 testing conducted across a jurisdiction and may be used in conjunction with percent of positive molecular tests to indicate whether a jurisdiction is sufficiently testing its population.
Data Elements	1. Number of COVID-19/SARS-CoV-2 molecular tests conducted 2. Number of COVID-19/SARS-CoV-2 serology tests conducted 3. Number of COVID-19/SARS-CoV-2 molecular tests conducted that were positive 4. Number of individuals planned to be tested (molecular)
Additional Guidance	This measure is about the total number of tests conducted. Numbers are inclusive of all tests conducted in your jurisdiction regardless of testing site. We understand there may or may not be a substantial discrepancy between the number of tests conducted and number of individuals tested; however, at this point in time, there is no way to differentiate between these two numbers through the CELR line-level data received by CDC. We encourage jurisdictions to de-duplicate test results whenever possible in order to better understand the burden of COVID-19 within the population. There are limitations to using percent positivity as an indicator of adequate testing capacity, and results will be contextualized with other factors. For example, a high percentage of positive test results may indicate that testing is occurring among a disproportionately high-risk population, or there is a high prevalence of COVID-19/SARS-CoV-2 overall circulating within the population. The percent of positive test results among all molecular test results may also be used to help gauge whether a jurisdiction has sufficient testing capacity in place, especially when it is applied to specific populations (e.g. high-risk demographics) and geographical areas (e.g. densely populated urban areas) *Number of tests conducted:* These include all tests (molecular, serology) and all test results (positive, negative and indeterminant). *Number of individuals planned to be tested:* This information is collected via the Jurisdictional Testing Plans as mandated by legislative language.
Target	≥ 2% of population tested per month (diagnostic testing) for the first year of funding during the remainder of calendar year 2020. While the target applies to diagnostic testing only, jurisdictions should evaluate and implement appropriate use of serology to better understand their population. This target may change over time.

Recommended Data Source	LIMS (#1-3) Jurisdictional Testing Plans (#4)
Reporting Frequency	Quarterly
Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.3: Proportion of COVID-19/SARS-CoV-2 laboratory test results submitted to CDC with complete information

Applicable Recipients	All states, NYC, DC, Philadelphia, Houston, Los Angeles County, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, Palau, Puerto Rico, and US Virgin Islands
Rationale	Assuring a rapid and thorough public health response to the COVID-19 pandemic necessitates comprehensive laboratory testing data. These data contribute to understanding disease incidence and trends, availability and use of testing resources, and identification of supply chain issues for reagents and other material. Laboratory testing data, in conjunction with case reports and other data, also provide vital guidance for mitigation and control activities. The intent of this measure is to look at the extent to which laboratory test result information being submitted to CDC through the CELR line-level data is complete, resulting in a more detailed and timely national picture of testing surveillance. ELC understands that completeness of these data may be reliant on the ordering provider; these data will be used to guide discussions between ELC and the recipient on how to work with ordering providers and clinical labs to improve data completeness.
Data Elements	For tests conducted within the PHL: 1. Numerator: Number of laboratory test results with complete information 2. Denominator: Number of laboratory test results For tests conducted at non-PHL laboratories/community testing sites: 3. Numerator: Number of laboratory test results with complete information 4. Denominator: Number of laboratory test results
Additional Guidance	This includes tests for all results. *Complete information:* A COVID-19/SARS-CoV-2 laboratory report with these critical data elements (as defined here: https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf) completed and sent to CDC will be considered "complete" with the following: 1. Test ordered – use harmonized LOINC codes provided by CDC 2. Device Identifier – use if LOINC codes do not indicate device/test kit 3. Test result 4. Test Result date 5. Accession #/Specimen ID 6. Age 7. Patient race 8. Patient ethnicity 9. Patient gender 10. Patient residence zip code 11. Patient residence county 12. Ordering provider name and NPI (as applicable) 13. Ordering provider zip 14. Performing Laboratory name or CLIA number, if known 15. Performing Laboratory zip code 16. Specimen Source - use appropriate LOINC, SNOMED-CT, SPM4 codes, or equivalently detailed alternative codes

	17. Date test ordered (date format) 18. Date specimen collected (date format)
Target	ELC plans to baseline completeness percentages for all variables and use that information to develop strategies for improvement. The ELC acknowledges that current percentages for completeness may be low.
Recommended Data Source	LIMS
Reporting Frequency	Quarterly
Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.4: Proportion of COVID-19/SARS-CoV-2 testing sites that received biosafety guidance and conducted laboratory risk assessments

Applicable Recipients	All states, NYC, DC, Philadelphia, Houston, Los Angeles County, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, Palau, Puerto Rico, and US Virgin Islands
Rationale	Safety of testing for COVID-19/SARS-CoV-2, in both laboratory and non-laboratory testing sites (e.g., prisons, nursing homes, drive-through testing sites), is an important concern. Public health departments are expected to conduct outreach and engage with testing facilities to improve safety of testing. All laboratories/testing sites should perform a site-specific and activity-specific risk assessment to identify and mitigate risks around COVID-19/SARS-CoV-2 testing. This measure looks at the extent and impact of outreach and engagement efforts on improving safety in non-PHL laboratories/community testing sites to help ensure that testing is done safely to protect personnel involved in performing procedures and collecting specimens.
Data Elements	1. Do you have a biosafety officer or technical staff to provide biosafety guidance? (Yes/No) a. If not, do you have plans to hire someone? (Yes/No) 2. Number of COVID-19/SARS-CoV-2 laboratories (excluding PHLs) that the public health department provided biosafety guidance 3. Number of COVID-19/SARS-CoV-2 non-laboratory testing sites (e.g., prisons, nursing homes, drive-through testing sites) that the public health department provided biosafety guidance 4. Number of COVID-19/SARS-CoV-2 laboratories (excluding PHLs) that have conducted a laboratory risk assessment for COVID-19 5. Number of COVID-19/SARS-CoV-2 non-laboratory testing sites (e.g., prisons, nursing homes, drive-through testing sites) that have conducted a laboratory risk assessment for COVID-19 6. Number of non-PHL COVID-19/SARS-CoV-2 laboratory and non-laboratory testing sites will be obtained from CELR line-level data submissions. We will share totals with recipients for validation. We understand this total may be less than the actual number of testing sites in your jurisdiction.
Additional Guidance	*Guidance:* Guidance can include training (virtual and in-person), communications (e-mail, phone calls, newsletters, flyers), in-person visits. *Risk assessment:* Includes identifying potential hazards, evaluating and prioritizing risks, deciding on and incorporating mitigation controls, and reviewing/evaluating effectiveness of controls. For more information about risk assessment, please refer to Guidelines for Safe Work Practices in Human and Animal Medical Diagnostic Laboratories: http://www.cdc.gov/mmwr/pdf/other/su6101.pdf. Additional guidance on biosafety practices around handling and processing COVID-19/SARS-CoV-2 specimens is provided here: https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-biosafety-guidelines.html APHL Biosafety and Biosecurity Resources: https://www.aphl.org/programs/preparedness/Pages/Biosafety-Biosecurity-Resources.aspx

Target	None at this time
Recommended Data Source	Surveys conducted with laboratories
Reporting Frequency	Twice per year
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.5: Proportion of COVID-19 cases submitted to CDC that include key data elements

Applicable Recipients	All states, NYC, DC, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, Palau, Puerto Rico, and US Virgin Islands
Rationale	The intent of this measure is to monitor the completeness of information provided by jurisdictions to CDC. Over time, efficient detection and reporting strategies (e.g., eCR, ELR, NNDSS MMGs) and additional staffing for case investigation and disease control should improve data completeness. This information is essential to CDC's understanding of the epidemiology of the disease and ability to guide prevention and control activities. Jurisdictions should strive to ensure that maximum completeness is achieved for the key variables listed below.
Data Elements	Denominator is total number of COVID cases submitted to CDC, unless otherwise specified. 1. Race - Numerator: number of cases with meaningful response (not missing/unknown) for race. 2. Ethnicity - Numerator: number of cases with meaningful response (not missing/unknown) for ethnicity. 3. Outbreak - Numerator: number of cases with meaningful response (not missing/unknown) for whether case was part of an outbreak. 4. Healthcare occupation - Numerator: number of cases with a specific healthcare occupation identified; Denominator: number of cases submitted to CDC indicating that patient is a healthcare worker. 5. Hospitalization - Numerator: number of cases with meaningful response (not missing/unknown) for hospitalization. 6. Exposure - Numerator: number of cases with meaningful response (not missing/unknown) for any exposure. 7. Symptoms - Numerator: number of cases with meaningful response (not missing/unknown) for symptoms indicator 8. Specific symptoms - Numerator: number of cases with a specific symptom identified; Denominator: number of cases submitted to CDC with "yes" for symptoms indicator. 9. Underlying medical conditions - Numerator: number of cases with meaningful response (not missing/unknown) for underlying medical conditions indicator. 10. Specific underlying medical conditions - Numerator: number of cases with a specific underlying medical condition identified; Denominator: number of cases submitted to CDC with "yes" for underlying medical conditions indicator. 11. Lab results - Numerator: number of cases with documentation of lab test result indicating infection; Denominator: number of confirmed cases submitted to CDC.
Additional Guidance	To the best of the jurisdiction's ability, initial reports should strive to capture and send basic demographic data and case status without delay. It is understood that other variables that require more case follow up to occur (e.g. interview, access to med records, etc.) may be delayed. https://www.cdc.gov/coronavirus/2019-ncov/downloads/pui-form.pdf A link to the COVID-19 MMG will be provided once available.
Target	≥ 90% for each

	Jurisdictions should strive for high levels of completeness on all data elements.
Recommended Data Source	Data quality reports produced from case surveillance data received at CDC
Reporting Frequency	Monthly
Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.6: Proportion of COVID-19 cases with individual-level data submitted to CDC

Applicable Recipients	All states, NYC, DC, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, Palau, Puerto Rico, and US Virgin Islands
Rationale	Aggregate counts submitted by jurisdictions to CDC limit CDC's ability to understand disease trends and patterns. This measure captures improvement in data quality related to electronic data flows. The intent of this measure is to monitor the extent to which jurisdictions provide case-level data on COVID-19 cases to CDC by comparing to the aggregate case counts.
Data Elements	1. Numerator: Cases with individual-level case information received at CDC 2. Denominator: Aggregate case counts
Additional Guidance	https://www.cdc.gov/coronavirus/2019-ncov/downloads/pui-form.pdf A link to the COVID-19 MMG will be provided once available.
Target	≥ 98%
Recommended Data Source	1. Numerator: NNDSS and DCIPHER 2. Denominator: Aggregate case counts
Reporting Frequency	Monthly
Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.7: Median number of days from date of first positive specimen collection (or when not available, diagnosis date) to date COVID-19 case is reported to CDC

Applicable Recipients	All states, NYC, DC, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, Palau, Puerto Rico, and US Virgin Islands
Rationale	The intent of this measure is to monitor improvements in the timeliness of COVID-19 case reporting to CDC. Recipients are expected to work with reporters to improve the speed with which COVID-19 cases are identified and reported to public health and the speed with which initial notification is provided to CDC. Timely data ensures that public health has up-to-date information on which to base decisions and actions.
Data Elements	Median number of days from date of first positive specimen collection (or when not available, diagnosis date) to date COVID-19 case is reported to CDC
Additional Guidance	To the best of the jurisdiction's ability, initial reports should strive to capture and send basic demographic data and case status without delay. It is understood that other variables that require more case follow up to occur (e.g. interview, access to med records, etc.) may be delayed. If both date of diagnosis and specimen collection date are available, the earlier of the two dates will be used for the calculation. https://www.cdc.gov/coronavirus/2019-ncov/downloads/pui-form.pdf https://wwwn.cdc.gov/nndss/case-notification/message-mapping-guides.html
Target	≤ 5 days
Recommended Data Source	Calculations based on COVID-19 case notifications to CDC through NNDSS and DCIPHER.
Reporting Frequency	Monthly
Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.8: Proportion of emergency department (ED) visits in the jurisdiction that are used for syndromic surveillance and shared with National Syndromic Surveillance Program (NSSP)

Applicable Recipients	All states, DC
Rationale	Syndromic surveillance provides public health with a timely system for detecting, understanding, and monitoring health events, including COVID-19. Recipients are expected to work with EDs in their jurisdiction to increase the number submitting syndromic surveillance data or increase the ED data transmitted to NSSP. The intent of this measure is to monitor the extent to which syndromic surveillance coverage of ED visits increases over time. From a jurisdiction and national perspective, full coverage of ED visits ensures that valid conclusions can be drawn for all geographic and population areas and that important findings are not missed due to coverage gaps.
Data Elements	1. Numerator: Number of ED visits shared with NSSP 2. Denominator: Total number of ED visits
Additional Guidance	Source for total number of ED visits can be an estimation from American Hospital Association or a state-specific source.
Target	≥ 90%
Recommended Data Source	NSSP calculations of ED visit coverage
Reporting Frequency	Quarterly
Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.9: Completeness of priority data elements in ED visits reported to NSSP

Applicable Recipients	All states, DC, NYC and Los Angeles County
Rationale	Recipients are expected to work with facilities submitting ED data to improve data element completeness. The intent of this measure is to monitor the completeness and validity of ED visit data, focusing on NSSP Priority 1 and 2 data elements. Increased completeness of information in the syndromic surveillance records improves public health's ability to detect and describe health events and the affected population groups and geographic areas.
Data Elements	1. Numerator: Number of ED visits with complete information for data elements 2. Denominator: Total number of ED visits shared with NSSP
Additional Guidance	Please review pages 27-28 of the BioSense Platform User Manual for Data-Quality-on-Demand-Programs (https://www.cdc.gov/nssp/biosense/docs/Data-Quality-On-Demand_User_Manual.pdf) for a list of key variables.
Target	Completeness of each Priority 1 and 2 data elements is ≥ 90%
Recommended Data Source	NSSP Data Quality Dashboard
Reporting Frequency	Quarterly
Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.10: Total number of patient visits reported each week by regularly reporting ILINet sites

Applicable Recipients	All states, NYC, DC, Chicago, Puerto Rico, Northern Mariana Islands, and US Virgin Islands. Other recipients may enroll providers if interested.
Rationale	The Outpatient Influenza-like Illness Surveillance Network, or ILINet, consists of volunteer sentinel outpatient providers, urgent care centers, and emergency departments. Providers who participate in the ILINet program collect and report information about the number of influenza-like illness (ILI) visits to their practice/facility each week. Mild to moderate COVID-19 illness presents with symptoms similar to ILI, so ILINet is now also being used to track trends of mild COVID-19 illness and allows for comparison with prior influenza seasons. There are currently more than 2,900 ILINet sentinel providers covering all 50 states, Puerto Rico, the District of Columbia, and the U.S. Virgin Islands. Data reported by ILINet providers provide a national picture of ILI activity in the U.S. Expanding the geographic distribution of ILINet providers and increasing their reporting frequency, as well as volume of patient visits, will improve our ability to detect and monitor community spread of SARS-CoV-2 and influenza. Establishing or maintaining one or more regularly reporting ILINet sites within each Core-Based Statistical Area (CBSA) that, in aggregate, see at least 150 patients per 100,000 population each week, will help each jurisdiction obtain more complete geographic coverage for syndromic surveillance for respiratory illnesses. For non-CBSA areas within a state, ILINet sites and patient visits should be commensurate with population size.
Data Elements	1. Number of patient visits reported each week by regularly reporting ILINet sites 2. Average number of patient visits reported each week by regularly reporting ILINet sites within each of the identified CBSAs
Additional Guidance	*Core-Based Statistical Area:* Metropolitan and Micropolitan Statistical Areas are collectively referred to as Core-Based Statistical Areas[1]. They are defined by the Office of Management and Budget (OMB) and consist of the county or counties or equivalent entities associated with at least one urban core (urbanized area or urban cluster) of at least 10,000 population, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties containing the core. *ILINet provider types:* Providers in many types of practices may be ILINet providers, including: • Emergency medicine • Family practice • Infectious disease • Internal medicine • OB/GYN • Pediatrics • Student health • Urgent care
Target	• Within each CBSA, at least 150 patient visits per 100,000 population captured in ILINet each week in the first 12 months of funding • Within each CBSA, at least 200 patient visits per 100,000 population captured in ILINet each week after 12 months

[1] https://www.census.gov/topics/housing/housing-patterns/about/core-based-statistical-areas.html

	• For non-CBSA areas of a state, maintain the number of providers and patient visits commensurate with the population. • 80% of ILINet sites routinely report, as measured by reporting at least 46 out of 52 weeks annually
Recommended Data Source	ILINet
Reporting Frequency	Quarterly
Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.11: Proportion of specimen testing results for all respiratory viruses tested at the public health laboratory that are submitted to CDC via PHLIP 2.5.1 with valid data for all key variables

Applicable Recipients	All states, NYC, DC, Philadelphia, Houston, and Los Angeles County American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, Palau, Puerto Rico, and US Virgin Islands
Rationale	Improving the completeness of laboratory reporting for respiratory viruses will help CDC gain a better understanding of the community and seasonal spread of COVID-19/SARS-CoV-2 vis-à-vis other respiratory viruses. Laboratory reporting for respiratory viruses, including SARS-CoV-2/COVID-19, influenza, RSV and others, must have complete information for all key variables to inform epidemiologic case investigations and follow up and to monitor trends in virus circulation. Submitting all public health laboratory reports for respiratory virus testing to CDC via PHLIP 2.5.1 will ensure that public health laboratory data can be used most effectively. This measure focuses on laboratory reporting for all respiratory virus specimens tested at the public health laboratory. ELC will collect a complementary measure (E.3) that focuses on reporting for COVID-19/ SARS-CoV-2 specimens tested at all laboratories, including at the public health laboratory and clinical laboratories.
Data Elements	**Data variables for all respiratory specimens tested:** • Specimen ID • Patient DOB (or age if DOB is not available) • Patient race/ethnicity • Patient zip code or county of residence (or zip code or county of submitting facility) • Specimen collection date • Virus test results • Level of care (inpatient/outpatient), when possible • Illness onset date, when possible • Specimen source, when possible • Gender, when possible **Additional data variable for respiratory specimens submitted by ILINet providers:** • ILINet provider ID
Additional Guidance	*PHLIP:* The Public Health Laboratory Interoperability Project (PHLIP) is a collaborative effort between the Association of Public Health Laboratories, CDC, and state public health laboratories (PHLs) to advance automated electronic data flows from PHLs to CDC.[2]
Target	At least 80% of reports for all respiratory virus testing at the public health laboratory are transmitted to CDC via PHLIP 2.5.1 and include valid data for all variables
Recommended Data Source	PHLIP
Reporting Frequency	Quarterly

[2] https://www.aphl.org/programs/informatics/Documents/INF_2013May15_ELSM-Overview.pdf

Reporting Mechanism	☐ REDCap ☒ CDC currently has this data and there is no need to report it at this time.

Measure E.12: Number of healthcare organizations engaged to implement electronic case reporting (eCR)

Applicable Recipients	All recipients
Rationale	**Jurisdictions must demonstrate that they are making electronic case reporting implementation with healthcare organizations a priority focus area through this funding**. Recipients are expected to recruit and work with healthcare organizations in their jurisdictions that submit reportable condition reports to implement electronic case reporting. The intent of this measure is to monitor the extent to which the number of healthcare organizations submitting electronic case reports to the jurisdiction increases over time. From a jurisdiction and national perspective, full coverage of healthcare organizations ensures that all cases of reportable conditions are identified for public health action.
Data Elements	1. Number and types of recruitment and outreach communications with healthcare organizations to promote implementation of eCR (e.g., recruitment letter, webinars, targeted discussions) 2. List of top 25 priority healthcare organizations for implementation of eCR. 3. Number of healthcare organizations actively engaged in eCR (testing and production) with the public health agency.
Additional Guidance	The agreed upon priority list of healthcare organizations in the jurisdiction will be used at quarterly calls between jurisdiction and the ELC HIS Implementation and Monitoring Team to track status of organization's implementation progress.
Target	2 outreach communications per organization within 6 months of award; Priority list within 3 months of award; Quarterly reporting on engagement status
Recommended Data Source	CDC will assist with providing an initial list of healthcare organizations in the jurisdiction if desired.
Reporting Frequency	Quarterly
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.13: Proportion of state reportable cases with an electronic initial case report (eICR) submitted

Applicable Recipients	All recipients
Rationale	Recipients are expected to work with healthcare organizations in their jurisdictions that submit reportable condition reports to increase the number submitting reports electronically. The intent of this measure is to monitor the extent to which cases in the jurisdiction have associated electronic case reports – either case was started by an eICR, an eICR was received and helped define the case status, or eICR received provided additional data to support the case. From a jurisdiction and national perspective, submission of electronic reports that are timely and complete will allow for more efficient and speedy public health action.
Data Elements	1. Numerator: Number of reportable cases with an associated electronic initial case report 2. Denominator: Total number of reportable cases known by the jurisdiction from all reporting mechanisms for state reportable conditions
Additional Guidance	Jurisdiction must maintain production connection with AIMS to receive eICRs
Target	50% by August 2021; overall target > 90%
Recommended Data Source	
Reporting Frequency	Twice per year
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.14: Demonstration of automatic processing of electronic initial case reports (eICRs) in the jurisdiction integrated surveillance system(s)

Applicable Recipients	All recipients
Rationale	Recipients are expected to ensure that their surveillance systems have capability to accept, process and present the data in electronic initial case reports (eICRs) and reportability responses (RRs) for use by users of the surveillance system. The intent of this measure is to monitor the surveillance system(s) ability to fully process the electronic case report data. Increased capacity to process electronic data improves public health's ability to identify and response to health events and the affected population groups and geographic areas.
Data Elements	1. List each surveillance system that is used to manage cases of reportable conditions a. For each surveillance system, indicate whether the system is fully able to automatically process incoming eICRs. (Yes/No) b. For one 30-day period: i. Numerator: Number of eICRs that processed into surveillance system without problem by condition ii. Denominator: Number of eICRS received per condition
Additional Guidance	Data from RR is needed to process eICR. Report measure for each surveillance system being used for managing reportable conditions. Conditions may vary by jurisdictions. "Without a problem" means no manual manipulation of the file was required to get data into the surveillance system. Just rendering the case report through the surveillance system is an interim solution and would not be counted as fully "processed" into the surveillance system.
Target	Processing of > 50% of eICRs by the surveillance system
Recommended Data Source	
Reporting Frequency	Twice per year
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.15: Proportion of test orders and results processed through Electronic Test Orders and Results (ETOR) at the PHL

Applicable Recipients	All states, NYC, DC, Philadelphia, Houston, Los Angeles County
Rationale	Electronic Test Orders and Results (ETOR) enable laboratories and healthcare providers to electronically exchange standardized test orders and results. Recipients are expected to work on enhancing laboratory test ordering and reporting capability with this project. The volume of orders and results data exchanged through ETOR by jurisdiction provides CDC an understanding of ETOR implementation occurring across the nation. Because the number of test orders received may be more than the number of test results provided by the PHL, understanding both would capture more completely the extent to which ETOR is occurring
Data Elements	1. Numerator: Number of test orders received by the PHL through ETOR 2. Denominator: Number of all test orders received by the PHL 3. Numerator: Number of test results sent through ETOR by the PHL 4. Denominator: Number of all test results sent by the PHL
Additional Guidance	This measure only applies to tests conducted at the public health laboratory. *Number of test results/orders:* This includes all test orders/results exchanged by the laboratory through all mechanisms (e.g., paper form, PDF Form, Email, through phone, mail, web portal, HL7 based message). *Number of test orders/results received through ETOR:* Includes all orders and results received or sent by electronic means including a web portal or an HL7 message. The web portal needs to be directly integrated to the LIMS to be considered valid for counting as "received or sent through ETOR". Please do not count tests which are transferred from portal to LIMS or vice versa by staff using mechanisms such as copy pasting or exporting to files by portal and upload to LIMS or other similar means for both orders and result reporting.
Target	None at this time.
Recommended Data Source	LIMS
Reporting Frequency	Twice per year
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.16: Systems/programs at the PHL with ETOR interfaces

Applicable Recipients	All states, NYC, DC, Philadelphia, Houston, Los Angeles County
Rationale	Electronic Test Orders and Results (ETOR) implementation is aimed at process automation within public health laboratories. This allows enhanced testing capacity by load management and reduction of errors due to manual data entry. The number of different programs/ systems connected electronically with healthcare providers is an indicator of the amount of process automation within the laboratory.
Data Elements	List of systems and/or programs within your public health laboratory that currently have fully implemented ETOR interfaces with any healthcare provider.
Additional Guidance	This measure only applies to systems/programs within the public health laboratory. Please list system/program if ETOR has been fully established with at least one healthcare provider. *Systems/programs:* This could include how the public health laboratory is categorized administratively or based on how LIMS implementations are divided. I.e., Infectious Disease Program, Microbiology Laboratory, Newborn Screening Laboratory, Pathology Laboratory. Recipients are encouraged to provide a list of systems/programs within their public health laboratory at the start of measurement period. *Healthcare providers:* Hospitals, Hospital systems, Physicians' offices or other entities receiving services from the public health laboratory.
Target	None at this time.
Recommended Data Source	Administrative System
Reporting Frequency	Annually
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.17: Number of cases assigned, per case investigator

Applicable Recipients	All recipients
Rationale	This ratio is essential for monitoring capacity and identifying needs to reallocate or obtain more staff or to further support staff. This is a reflection of staff capacity to do this work as well as a reflection of the demand for case investigation and contact tracing, and whether that demand can be met with existing capacity. For this reason, it is important to track on a more frequent basis, as contact tracing programs scale up and as the epidemiology of COVID-19 changes. The information will help prompt important discussions about variations in workload over time and across jurisdiction. In analysis of this measure, cases assigned will also be compared to cases reported from the jurisdiction, to identify areas with large gaps between those and understand reasons for those gaps.
Data Elements	1. Number of COVID-19 cases assigned Total number of cases formally assigned for follow-up to a staff person. This is usually automated within the case investigation system, when a case is flagged or prioritized for investigation 2. Number of case investigators Total number of unique staff who were assigned those cases (referenced above), during the reporting period.
Additional Guidance	Cases assigned is not the same as cases worked, or actively followed-up on, though they should approximate one another. Cases may be probable or confirmed; they may reflect all cases or a subset of cases prioritized for follow-up in a jurisdiction. These are dependent on each jurisdiction's protocols and prioritization schemes. The total numbers here will flatten the extensive variation in workload by individual staff person (within a program) and over time (within a single month).
Target	No target
Recommended Data Source	Case investigation management system
Reporting Frequency	Monthly, covering the four-week period that ends 1 week before the reporting deadline
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.18: Number of contacts assigned, per contact tracer

Applicable Recipients	All recipients
Rationale	This ratio is essential for monitoring capacity and identifying needs to reallocate or obtain more staff or to further support staff in other ways. This is a reflection of staff capacity to do this work as well as a reflection of the demand for case investigation and contact tracing, and whether that demand can be met with existing capacity. For this reason, it is important to track on a more frequent basis, as contact tracing programs scale up and as the epidemiology of COVID-19 changes. The information will help prompt important discussions about variations in workload over time and across jurisdiction.
Data Elements	1. Close contacts assigned Total number of close contacts formally assigned for follow-up to a staff person. This is usually automated within the case investigation and contact tracing system, when a contact is flagged or prioritized for follow-up. 2. Contact tracers Total number of unique staff who were assigned those contacts (referenced above), during that reporting period 3. During the reporting period, were the contact tracing staff separate from case investigation staff Select one: Yes, they were all separate staff people; Mostly separate, as some case investigators did some contact tracing (or vice versa); No, they were all the same staff, who did both jobs
Additional Guidance	Contacts assigned is not the same as those worked, or actively followed-up on. The total numbers here will flatten the extensive variation in workload by individual staff person (within a program) and over time (within a single month). Some jurisdictions have separate case investigation and contact tracing programs and staff; others have merged programs and staff. Data Element 3 above will help CDC obtain basic information about the program design, to help contextualize the numbers provided. In jurisdictions where contact tracing is completed by case investigators, the denominator will be the same for the two workload measures; such jurisdictions should select "No, they were all the same staff" for Data Element 3. In jurisdictions where <u>some</u> contact tracing is completed by case investigators (e.g., within a household of a case), jurisdictions should select answer two for Data Element 3.
Target	No target
Recommended Data Source	Contact tracing management system

Reporting Frequency	Monthly, covering the four-week period that ends 1 week before the reporting deadline
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.19: Among cases prioritized for case investigation, proportion interviewed within 24 hours of report to the case investigation unit

Applicable Recipients	All recipients
Rationale	The intent of this measure is to monitor the timeliness of occurrence of case interviews following case report to the case investigation unit. Interviewing cases in a timely manner after case report increases the likelihood of quickly identifying contacts, allowing for more timely detection of additional COVID-19/SARS-CoV2 cases. Speed of follow- up is essential for public health impact, for the case and their contacts, in order to mitigate the spread of disease.
Data Elements	1. Number of COVID-19 cases prioritized for case investigation This should include the COVID-19 cases (confirmed and probable) reported to the recipient health department, in the official case report system, and which are prioritized for case investigation. This should include the vast majority, if not all, cases reported. 2. Number of those cases (referenced above) interviewed within 24 hours of report Interviewed = Successfully reached by a health department staff person or representative. The method of interview is not defined and can vary depending on recipients' methods and among cases (phone, email, in person, other). Within 24 hours of report = 1st notification of a case (lab or provider) to the health department's case investigation unit. This may be different than the date of first report to any part of the health department. This acknowledges that systems may have gaps between lab report and transfer to the case investigation unit's data system. If time cannot be tracked by the hour, then jurisdictions could calculate this as "within 1 day" instead.
Additional Guidance	Recipients should also try to track (not for submission to CDC) other aspects of case investigation workflow, such as: speed with which confirmed or probable cases are reported to the case investigation unit or system, # and characteristics of cases that are prioritized for case investigation (if not all are investigated), timing of first attempt to contact, # of contact attempts, # interviewed (any time period, median time lag) Timely reporting of cases by laboratories and providers is critical, as jurisdictions may opt not to assign late reports for interview because of limited window to intervene. Jurisdictions should monitor instances where cases were not alerted to the importance of isolation before the case interview, as it could demonstrate a need for provider or public education.
Target	The target for this measure is still under development; there is a need to see what is realistic and how this target needs to change over time, depending on epidemiology and capacity. There is no expectation that 100% of cases would be interviewed within 24 hours or 1 day.
Recommended Data Source	Case investigation data system
Reporting Frequency	Monthly, covering the four-week period that ends 1 week before the reporting deadline

Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.20: Among close contacts identified by cases interviewed, proportion notified within 24 hours of initiation for follow-up

Applicable Recipients	All recipients
Rationale	The intent of this measure is to monitor the timeliness of contact notification following case report. Identifying and notifying contacts of COVID-19/SARS-CoV2 cases in a timely manner allows for detection of possible COVID-19/SARS-CoV2 cases. Speed of follow-up is essential for stopping or mitigating further disease spread, particularly for COVID-19.
Data Elements	1. Number of close contacts elicited by cases interviewed "Close contacts elicited" = these may reflect only the highest priority contacts that an area identifies for contact tracing, not necessarily all contacts that a case could potentially name. These generally would be the contacts that an area would enter into their contact tracing information system. This would depend on each jurisdiction's protocol. An elicited contact is one with sufficient information that allows for follow up. 2. Number of close contacts (reference above) notified within 24 hours of initiation for follow-up "Notified" = Informed of one's potential exposure to a COVID-19 case. Method of notification is not defined and can vary depending on recipients' methods and among cases (text, phone, email, other). Notification does not necessarily require an interview, but it should involve confirmed receipt of the information. Attempted or unsuccessful notification should not be included here. Within 24 hours of initiation for follow-up = From the time when the contact was initiated within the contact tracing system for follow-up by the health department or its representative. If time cannot be tracked by the hour, then jurisdictions could calculate this as "within 1 day" instead.
Additional Guidance	Recipients should also try to track other aspects of the contact tracing workflow (not for submission to CDC), such as: # contacts elicited, # notified (any time period), # interviewed (any time period, within 24 hours), self-quarantine status and timeliness, # who enroll in illness monitoring system, # lost to follow-up, final disposition
Target	The target for this measure is still under development; there is a need to see what is realistic and how this target needs to change over time, depending on epidemiology and capacity. There is currently no expectation that 100% of contacts would be notified within 24 hours or 1 day.
Recommended Data Source	Contact tracing data system
Reporting Frequency	Monthly, covering the four-week period that ends 1 week before the reporting deadline
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.21: Among contacts notified, proportion tested for COVID-19/SARS-CoV-2 at least once, within 14 days of notification

Applicable Recipients	All recipients
Rationale	Obtaining information on the extent of testing among contacts is important because it reflects both testing capacity and public health intervention to reduce the spread of COVID-19. Monitoring the extent of testing conducted within contact tracing process is important for better understanding how contact tracing programs are implemented and evolve over time, across jurisdictions.
Data Elements	1. Number of contacts notified Notified = Informed of one's potential exposure to a person known to have COVID-19, by the health department or its representative. Method of notification is not defined and can vary depending on recipients' methods and among contacts (text, phone, email, other). These typically would include a subset of all close contacts elicited from a case. 2. Number of notified contacts tested for COVID-19 at least once within 14 days of notification Testing = By self-report or lab result received (assuming negative lab results come to recipient). Tested using a diagnostic test, for current/active infection, not antibody testing. Antibody testing should not be included in this measure.
Additional Guidance	Testing capacity and testing protocols vary across recipients, so it may be difficult to compare this measure across recipients. Some contacts may be appropriately managed without testing, so this measure does not reflect the percent of contacts who were appropriately managed. Some testing may be difficult to capture, if the contact is tested on their own or if there are gaps in reporting of testing to the health department (by testing agencies or the contact). If a contact got tested after being notified by the case (not the health department or its representative),
Target	No target at this time.
Recommended Data Source	Contact tracing data system
Reporting Frequency	Quarterly
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.22: Number of new confirmed or probable COVID-19 cases identified among contacts in the contact tracing system, within 14 days of last exposure to the index case

Applicable Recipients	All recipients
Rationale	This is considered the key outcome measure for contact tracing: the identification of new cases. This reflects the relative contribution of contact tracing to case identification. If low, the value of contact tracing may be low and need revisiting. This number would be used as a numerator, with all cases reported (for a particular time frame) as a denominator, so CDC could calculate the proportion of all diagnosed cases in jurisdiction arising from contacts in the contact tracing system. Recipients could also analyze this number over all contacts elicited or all contacts interviewed to calculate the number needed to interview to identify a new case of COVID-19.
Data Elements	1. Number of new confirmed or probable COVID-19 cases identified among contacts in the contact tracing system, within 14 days of last exposure to the index case New COVID-19 cases = those cases in the recipients' COVID-19 surveillance system, categorized as confirmed or probable Among contacts in the contact tracing system = A new case was previously a contact that had been entered in the recipients' contact tracing system. The contact was therefore known by the recipient to some degree prior to becoming a case. The contact may or may not have been notified, self-quarantined, or been tested (i.e. inclusion in this measure is not tied to being included in the above contact tracing measure). The measure does not assume any particular level of public health intervention. 14 days of last exposure to the index case = the 14 days from the day that the health department or its representative marks the start of self-quarantine for the contact. The contact may have tested positive in this period prior to interaction with the health department or its representative. In this way, the measure is not a direct reflection of program effort, but it does reflect a critical aspect of new case identification, tied to contacts. These issues are important to bear in mind for interpretation of this measure.
Additional Guidance	This requires record linkage between COVID-19 surveillance system and the contact tracing system or some duplication of data across systems (e.g. a contact could have a disposition code of "confirmed COVID-19 positive" which could be used to calculate this, or it could be based on formal matching between data systems). It is understood that not all jurisdictions currently have this capacity. Much happens between a contact being notified and appearing in this measure- i.e., likely COVID-19 testing, perhaps symptoms development, health care engagement, referrals. This measure jumps to a distal outcome, and thus none of those interim steps are captured here. Because individuals' trajectory to becoming a COVID-19 case can vary so much, CDC opted not to try to assess many steps in that process. It is difficult to measure such processes consistently across recipients.
Target	No target at this time.
Recommended Data Source	Case surveillance and contact tracing systems

Reporting Frequency	Quarterly
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.23: Number of health department staff who can perform healthcare infection control assessments at state and local level

Applicable Recipients	All recipients
Rationale	Strengthening the infection prevention and control expertise can influence a health department's ability to respond to COVID-19 and other infectious diseases outbreaks. Tracking the number of people who can perform ICAR assessments is an essential component of monitoring progress and identify areas for improvement or point to gaps in IPC workforce development at the state and local level.
Data Elements	1. No. of state HD staff who can independently and capably perform an ICAR assessment in healthcare facilities, provide prevention and outbreak response recommendations to facilities, and follow-up with facilities to ensure gaps have been mitigated. 2. No. of local HD staff who can independently and capably perform an ICAR assessment in healthcare facilities, provide prevention and outbreak response recommendations to facilities, and follow-up with facilities to ensure gaps have been mitigated.
Additional Guidance	Health department staff can include hired and/or contracted by the HD
Target	N/A
Recommended Data Source	N/A
Reporting Frequency	Twice per year
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Measure E.24: Number of healthcare infection control assessment and response (ICAR) conducted by the health department or designee for COVID-19, by method, setting, type (reactive or proactive), and entity that completed the assessment

Applicable Recipients	All recipients
Rationale	The health department plays a critical role in responding to possible COVID-19 HAI/AR outbreaks. Understanding the types (reactive or proactive) of assessments conducted, by method, and setting type, allows CDC and the HDs to track IPC issues and settings requiring the greatest public health support. Beyond the ICARs, HDs should follow up after the assessment to support healthcare settings in implementing recommendations.
Data Elements	Number of healthcare facilities in your jurisdiction where an ICAR was conducted by health department or designee, by: 1. Method: remote (i.e., Tele-ICAR, video-ICAR) or on-site 2. Setting: acute care hospitals, inpatient rehabilitation facilities, long-term acute care hospitals, nursing homes/skilled nursing facilities, assisted living facilities and other congregate living settings, dialysis facilities, federally qualified health centers (FQHCs), critical access hospitals, dental offices, and other outpatient settings. 3. Type: reactive (in response to cases) or proactive (prevention-based) 4. Entity(s) that completed the assessment (e.g., state HAI/AR Program, other state health department program, QIN/QIO, local or regional public health department, CDC, academic partner, other).
Additional Guidance	Provision of remote/onsite assistance to assess infection control issues may be done directly by the Recipient or through the support of a local health department, academic partner, contractor, consultant, or other entity (designee) for which the Recipient can assure the quality of services provided. Include all ICARs conducted, whether a CDC ICAR or a modified ICAR. The CDC Tele-ICAR tools can be used to conduct on site or over the phone assessment; an example, specific to COVID-19 guidance for nursing homes, is available at this link. Proactive infection control assessments are those that focus on facilities considered to be at high risk for COVID-19 outbreaks, with the goal of improving infection control practices to reduce transmission of COVID-19. This type of infection control assessment is distinct from response-driven infection control assessments that are focused on facilities where COVID-19 or other HAI/AR infections outbreaks have been identified.
Target	N/A
Recommended Data Source	N/A
Reporting Frequency	Twice per year

Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it currently.

Measure E.25: Number of COVID-19 outbreaks and responses in healthcare settings

Applicable Recipients	All recipients
Rationale	Rapid and structured response is critical to the successful containment of COVID-19 in healthcare settings. An understanding of this information can help CDC and HD quantify the extent of the issue and assess whether timely and efficient response is implemented.
Data Elements	1. HD maintains a system that is capable of classifying healthcare facilities according to current COVID status (e.g., non-outbreak, possible outbreak, confirmed outbreak). (Yes/No) a. If Yes, select which system you use to track and classify facilities (e.g., NHSN LTCF COVID-19 module, state-developed system, other system). 2. Number of COVID-19 outbreaks in healthcare settings that the HD or designee responded to within a specified time period by setting
Additional Guidance	Response refers to a series of actions on the part of public health authorities to assess specific, acute HAI/AR risks and prevent further harm. Response efforts may take the form of consultation regarding IPC activities, remote or on-site assessments, or other IPC technical assistance (e.g. cohorting or testing strategies, return to work criteria, PPE optimization, mitigating staffing shortages), to facilities with COVID-19 infections among residents/patients or HCP. Note that definition of "outbreak", "responded to" and "specified time period" will be defined in the REDCap reporting template.
Target	N/A
Recommended Data Source	N/A
Reporting Frequency	Twice per year
Reporting Mechanism	☒ REDCap ☐ CDC currently has this data and there is no need to report it at this time.

Appendix A. Reporting Mechanism by Measure

ID	Measure	REDCap	CDC has data and will share with recipients
E.1	Median number of days from specimen collection date to date of report of final test result for COVID-19/SARS-CoV-2 molecular diagnostic tests	X	X
E.2	Number of COVID-19/SARS-CoV-2 tests completed by test type and result		X
E.3	Proportion of COVID-19/SARS-CoV-2 laboratory test results submitted to CDC with complete information		X
E.4	Proportion of COVID-19/SARS-CoV-2 testing sites that received biosafety guidance and conducted laboratory risk assessments	X	
E.5	Proportion of COVID-19 cases submitted to CDC that include key data elements		X
E.6	Proportion of COVID-19 cases with individual-level data provided by public health jurisdictions to CDC		X
E.7	Median number of days from date of first positive specimen collection (or when not available, diagnosis date) to date COVID-19 case is reported to CDC		X
E.8	Proportion of emergency department (ED) visits in the jurisdiction that are used for syndromic surveillance and shared with National Syndromic Surveillance Program (NSSP)		X
E.9	Completeness of priority data elements in ED visits reported to NSSP		X
E.10	Total number of patient visits reported each week by regularly reporting ILINet sites		X
E.11	Proportion of specimen testing results for all respiratory viruses tested at the public health laboratory that are submitted to CDC via PHLIP 2.5.1 with valid data for all key variables		X
E.12	Number of healthcare organizations engaged to implement electronic case reporting (eCR)	X	
E.13	Proportion of state reportable disease cases with an electronic initial case report (eICR) submitted	X	
E.14	Demonstration of automatic processing of electronic initial case reports (eICRs) in the jurisdiction integrated surveillance system(s)	X	
E.15	Proportion of test orders and results processed through (Electronic Test Orders and Results) ETOR at the PHL	X	
E.16	Systems/programs at the PHL with ETOR interfaces	X	
E.17	Number of cases assigned, per case investigator	X	
E.18	Number of contacts assigned, per contact tracer	X	
E.19	Among cases prioritized for case investigation, proportion interviewed within 24 hours of case report to the case investigation unit	X	
E.20	Among close contacts identified by cases interviewed, proportion notified within 24 hours of initiation for follow-up	X	
E.21	Among contacts notified, proportion tested for COVID-19 at least once, within 14 days of notification	X	

ID	Measure	REDCap	CDC has data and will share with recipients
E.22	Number of new confirmed or probable COVID-19 cases identified among contacts in the contact tracing system, within 14 days of last exposure to the index case	X	
E.23	Number of health department staff who can perform healthcare infection control assessments at state and local level	X	
E.24	Number of healthcare infection control assessment and response (ICAR) conducted by the health department or designee for COVID-19, by method, setting, type (reactive or proactive), and entity that completed the assessment	X	
E.25	Number of COVID-19 outbreaks and responses in healthcare settings	X	

Appendix B. Reporting Frequency (for Recipient-Reported Measures only)

ID	Measure	Reporting Frequency
E.1	Median number of days from specimen collection date to date of report of final test result for COVID-19/SARS-CoV-2 molecular diagnostic tests	Quarterly
E.4	Proportion of COVID-19/SARS-CoV-2 testing sites that received biosafety guidance and conducted laboratory risk assessments	Quarterly
E.12	Number of healthcare organizations engaged to implement electronic case reporting (eCR)	Twice per year
E.13	Proportion of state reportable disease cases with an electronic initial case report (eICR) submitted	Twice per year
E.14	Demonstration of automatic processing of electronic initial case reports (eICRs) in the jurisdiction integrated surveillance system(s)	Twice per year
E.15	Proportion of test orders and results processed through Electronic Test Orders and Results (ETOR) at the PHL	Twice per year
E.16	Systems/programs at the PHL with ETOR interfaces	Annually
E.17	Number of cases assigned, per case investigator	Monthly
E.18	Number of contacts assigned, per contact tracer	Monthly
E.19	Among cases prioritized for case investigation, proportion interviewed within 24 hours of case report to the case investigation unit	Monthly
E.20	Among close contacts identified by cases interviewed, proportion notified within 24 hours of initiation for follow-up	Monthly
E.21	Among contacts notified, proportion tested for COVID-19 at least once, within 14 days of notification	Quarterly
E.22	Number of new confirmed or probable COVID-19 cases identified among contacts in the contact tracing system, within 14 days of last exposure to the index case	Quarterly
E.23	Number of health department staff who can perform healthcare infection control assessments at state and local level	Twice per year
E.24	Number of healthcare infection control assessment and response (ICAR) conducted by the health department or designee for COVID-19, by method, setting, type (reactive or proactive), and entity that completed the assessment	Twice per year
E.25	Number of COVID-19 outbreaks and responses in healthcare settings	Twice per year

Exhibit I

1. DATE ISSUED *MM/DD/YYYY*
05/18/2020

1a. SUPERSEDES AWARD NOTICE dated 05/05/2020
except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

2. CFDA NO.
[redacted] - Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

3. ASSISTANCE TYPE Cooperative Agreement

4. GRANT NO. [redacted]
Formerly

5. TYPE OF AWARD
Demonstration

4a. FAIN [redacted]

5a. ACTION TYPE Post Award Amendment

6. PROJECT PERIOD *MM/DD/YYYY*
From 08/01/2019 Through *MM/DD/YYYY* 07/31/2024

7. BUDGET PERIOD *MM/DD/YYYY*
From 08/01/2019 Through *MM/DD/YYYY* 07/31/2020

8. TITLE OF PROJECT (OR PROGRAM)
PHFE CDPH ELC 2019-2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

[redacted]

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)
301(A)AND317(K)(2)PHS42USC241(A)247B(K)2

9a. GRANTEE NAME AND ADDRESS
Public Health Foundation Enterprises, Inc.
[redacted]

9b. GRANTEE PROJECT DIRECTOR
[redacted]

10a. GRANTEE AUTHORIZING OFFICIAL
[redacted]

10b. FEDERAL PROJECT OFFICER
[redacted]

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes Direct Assistance)

I Financial Assistance from the Federal Awarding Agency Only
II Total project costs including grant funds and all other financial participation — I

a.	Salaries and Wages	4,376,406.00
b.	Fringe Benefits	1,574,695.00
c.	Total Personnel Costs	5,951,101.00
d.	Equipment	262,000.00
e.	Supplies	1,532,769.00
f.	Travel	246,619.00
g.	Construction	0.00
h.	Other	541,606,799.00
i.	Contractual	1,571,792.00
j.	TOTAL DIRECT COSTS	551,171,080.00
k.	INDIRECT COSTS	1,150,907.00
l.	**TOTAL APPROVED BUDGET**	552,321,987.00
m.	Federal Share	552,321,987.00
n.	Non-Federal Share	0.00

12. AWARD COMPUTATION

a. Amount of Federal Financial Assistance (from item 11m)	552,321,987.00
b. Less Unobligated Balance From Prior Budget Periods	0.00
c. Less Cumulative Prior Award(s) This Budget Period	53,118,807.00
d. **AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION**	499,203,180.00
13. Total Federal Funds Awarded to Date for Project Period	552,321,987.00

14. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES: b

a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER *(See REMARKS)*

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARDING AGENCY ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:

a. The grant program legislation
b. The grant program regulations.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - ☒ Yes ☐ No)
ELC Enhancing Detection Funding: Financial Assistance in the amount of $499,203,180

GRANTS MANAGEMENT OFFICIAL:
[redacted]

17.OBJ CLASS 41.51	18a. VENDOR CODE [redacted]	18b. EIN [redacted]	19. DUNS [redacted]	20. CONG. DIST. 32
FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	APPROPRIATION
21. a. [redacted]	b. [redacted]	c. CK	d. $499,203,180.00	e. [redacted]
22. a.	b.	c.	d.	e.
23. a.	b.	c.	d.	e.

NOTICE OF AWARD (Continuation Sheet)

PAGE 2 of 3	DATE ISSUED 05/18/2020
GRANT NO. [redacted]	

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

NOTICE OF AWARD (Continuation Sheet)

PAGE 3 of 3	DATE ISSUED 05/18/2020
GRANT NO. [redacted]	

Federal Financial Report Cycle			
Reporting Period Start Date	Reporting Period End Date	Reporting Type	Reporting Period Due Date
08/01/2019	07/31/2020	Annual	10/29/2020

AWARD ATTACHMENTS

Public Health Foundation Enterprises, Inc. [redacted]

1. Terms and Conditions

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Non-research awards at https://www.cdc.gov/grants/federalregulationspolicies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number CK19-1904, entitled Epidemiology and Laboratory Capacity (ELC), which is hereby made a part of this Non-research award, hereinafter referred to as the Notice of Award (NoA).

Component Funding: Additional funding in the amount $499,203,180 is approved for the Year 01 budget period, which is August 1, 2019 through July 31, 2020

COVID-19 Paycheck Protection Program and Health Care Enhancement Act Response Activities:

E. Cross-Cutting Emerging Issues: $499,203,180

Recipients have **30 months** from the date of this NoA to expend all funds awarded herein

Budget/Workplan Revision Requirement: Within 30 days of this NoA, the recipient must submit a revised budget with a narrative justification outlining response activities. Failure to submit the required information in a timely manner may adversely affect the future funding of the project. If the information cannot be provided by the due date, you are required to contact your ELC Project Officer and Grant Management Specialist. The revised budget must be uploaded in GrantSolutions as an amendment to allow issuance of a revised NoA.

Pre-Award Costs: Pre-award costs dating back to January 20, 2020 – when CDC first activated its Emergency Operations Center (EOC) – and directly related to the COVID-19 outbreak response are allowable.

Indirect Costs: Indirect cost will be approved based on current approved negotiated indirect cost rate agreement.

Overtime: Because overtime costs are a very likely and reasonable expense during the response to COVID-19, CDC will allow recipients to include projected overtime in their budgets. Recipients should be careful to estimate costs based on current real-time needs and will still be required to follow federal rules and regulations in accounting for the employees' time and effort.

Additional Term and Condition:
A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the "CARES Act") (P.L. 116-136); and/or the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) agrees, as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health measures (e.g., social distancing, home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation.

In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS–CoV–2 or to diagnose a possible case of COVID–19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC.

Further, consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the

purpose of this award, and the underlying funding, the recipient is expected to provide to CDC copies of and/or access to COVID-19 data collected with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.

This award is contingent upon agreement by the recipient to comply with existing and future guidance from the HHS Secretary regarding control of the spread of COVID-19. In addition, recipient is expected to flow down these terms to any subaward, to the extent applicable to activities set out in such subaward.

Unallowable Costs:

- Research
- Clinical care
- Publicity and propaganda (lobbying):
    - Other than for normal and recognized executive-legislative relationships, no funds may be used for:
        - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
        - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
    - See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients: https://www.cdc.gov/grants/documents/Anti-Lobbying_Restrictions_for_CDC_Grantees_July_2012.pdf

- ***All unallowable costs cited in CDC-RFA-CK19-1904 remain in effect, unless specifically amended in this guidance, in accordance with 45 CFR Part 75 – Uniform Administrative Requirements, Cost Principles, And Audit Requirements for HHS Awards.***

REPORTING REQUIREMENTS

Additional Reporting:

- Monthly fiscal reports (beginning 60 days after NOAs are issued)
- Quarterly progress reports on status of timelines, goals, and objectives as defined by CDC in approved work plans
- Quarterly Performance measure data
- CDC may require recipients to develop annual progress reports (APRs). CDC will provide APR guidance and optional templates should they be required.
- Quarterly reporting of test results, both positive and negative
- Clarity on how the states will focus on high socially vulnerable index counties, rural and urban areas, etc. (Vulnerable populations must be specific).

Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the

following addresses:

CDC, Office of Grants Services
[redacted]
[redacted]@cdc.gov | [redacted]

AND

U.S. Department of Health and Human Services Office of the Inspector General
ATTN: Mandatory Grant Disclosures, [redacted]

Fax: [redacted] (Include "Mandatory Grant Disclosures" in subject line) or Email: MandatoryGranteeDisclosures@oig.hhs.gov

Recipients must include this mandatory disclosure requirement in all subawards and contracts under this award.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

CDC is required to report any termination of a federal award prior to the end of the period of performance due to material failure to comply with the terms and conditions of this award in the OMB-designated integrity and performance system accessible through SAM (currently FAPIIS). (45 CFR 75.372(b)) CDC must also notify the recipient if the federal award is terminated for failure to comply with the federal statutes, regulations, or terms and conditions of the federal award. (45 CFR 75.373(b))

PAYMENT INFORMATION

The HHS Office of the Inspector General (OIG) maintains a toll-free number (1- 800-HHS- TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application.

The grant document number identified on the bottom of Page 1 of the Notice of Award must be known in order to draw down funds.

Stewardship: The recipient must exercise proper stewardship over Federal funds by ensuring that all costs charged to your cooperative agreement are allowable, allocable, and reasonable and that they address the highest priority needs as they relate to this program.

All the other terms and conditions issued with the original award remain in effect throughout the budget period unless otherwise changed, in writing, by the Grants Management Officer.

Exhibit J

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 01/13/2021

Recipient Information

1. Recipient Name

Public Health Foundation Enterprises, Inc.
[redacted]
[NO DATA]

2. Congressional District of Recipient
32

3. Payment System Identifier (ID)
[redacted]

4. Employer Identification Number (EIN)
[redacted]

5. Data Universal Numbering System (DUNS)
[redacted]

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator
[redacted]

8. Authorized Official
[redacted]

Federal Agency Information
CDC Office [redacted]

9. Awarding Agency Contact Information
[redacted]

10. Program Official Contact Information
[redacted]

Federal Award Information

11. Award Number
[redacted]

12. Unique Federal Award Identification Number (FAIN)
[redacted]

13. Statutory Authority
301(A)AND317(K)(2)PHS42USC241(A)247B(K)2

14. Federal Award Project Title
PHFE CDPH ELC 2019-2024

15. Assistance Listing Number
93.323

16. Assistance Listing Program Title
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

17. Award Action Type
Supplement

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. **Budget Period Start Date** 08/01/2020 - **End Date** 07/31/2021	
20. **Total Amount of Federal Funds Obligated by this Action**	$1,696,424,899.00
20a. Direct Cost Amount	$1,696,424,899.00
20b. Indirect Cost Amount	$0.00
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$20,292,035.00
24. **Total Approved Cost Sharing or Matching, where applicable**	$0.00
25. **Total Federal and Non-Federal Approved this Budget Period**	$1,716,716,934.00
26. **Project Period Start Date** 08/01/2019 - **End Date** 07/31/2024	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$2,272,733,645.00

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
[redacted]

30. Remarks

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 01/13/2021

Recipient Information

Recipient Name

[redacted]

Congressional District of Recipient
32

Payment Account Number and Type
[redacted]

Employer Identification Number (EIN) Data
[redacted]

Universal Numbering System (DUNS)
[redacted]

Recipient's Unique Entity Identifier
Not Available

31. Assistance Type
Cooperative Agreement

32. Type of Award
Demonstration

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$4,880,129.00
b. Fringe Benefits	$1,727,498.00
c. Total Personnel Costs	$6,607,627.00
d. Equipment	$207,355.00
e. Supplies	$892,462.00
f. Travel	$77,420.00
g. Construction	$0.00
h. Other	$1,706,022,035.00
i. Contractual	$1,677,380.00
j. TOTAL DIRECT COSTS	$1,715,484,279.00
k. INDIRECT COSTS	$1,232,655.00
l. TOTAL APPROVED BUDGET	$1,716,716,934.00
m. Federal Share	$1,716,716,934.00
n. Non-Federal Share	$0.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
[redacted]	[redacted]	CK	41.51	$0.00	[redacted]
[redacted]	[redacted]	CK	41.51	$1,696,424,899.00	[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES Notice of Award

Centers for Disease Control and Prevention

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 01/13/2021

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

AWARD ATTACHMENTS

Public Health Foundation Enterprises, Inc. [redacted]

1. YR 2 Supplemental Terms and Conditions

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Non-research awards at https://www.cdc.gov/grants/federalregulationspolicies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number CK19-1904, entitled Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC), which are hereby made a part of this Non-research award, hereinafter referred to as the Notice of Award (NoA).

Supplemental Component Funding: Additional funding in the amount $1,696,424,899 is approved for the Year 02 budget period, which is August 1, 2020 through July 31, 2021.

The approved component and funding level for this notice of award are:

NOFO Component	Amount
ELC Enhancing Detection Expansion	$1,696,424,899

Recipients have until July 31, 2023 to expend all COVID-19 funds awarded herein.

Overtime: Because overtime costs are a very likely and reasonable expense during the response to COVID-19, CDC will allow recipients to include projected overtime in their budgets. Recipients should be careful to estimate costs based on current real-time needs and will still be required to follow federal rules and regulations in accounting for the employees' time and effort.

Coronavirus Disease 2019 (COVID-19) Funds: A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the "CARES Act") (P.L. 116-136); the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139); and/or the Consolidated Appropriations Act, 2021, Division M – Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (P.L. 116-260), agrees, as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health measures (e.g., social distancing, home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation.

To achieve the public health objectives of ensuring the health, safety, and welfare of all Americans, Recipient must distribute or administer vaccine without discriminating on non-public-health grounds within a prioritized group. This includes, but is not limited to, immigration status, criminal history, incarceration, or homelessness. To this end, and to help achieve the public health imperative of widespread herd immunity to COVID-19, Recipient must administer or distribute vaccine to any and all individuals within a prioritized group in the same timeframe, taking into account available vaccine doses. For example, if meatpacking plant workers are a prioritized group, then all workers in that group, including undocumented immigrants, must be vaccinated to help assure that the plant is in a position to safely resume essential functions.

In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS–CoV–2 or to diagnose a possible case of COVID–19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC. HHS laboratory reporting guidance is posted at: https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf.

Further, consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the purpose of this award, and the underlying funding, the recipient is expected to provide to CDC copies of and/or access to COVID-19 data collected with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.

This award is contingent upon agreement by the recipient to comply with existing and future guidance from the HHS Secretary regarding control of the spread of COVID-19. In addition, recipient is expected to flow down these terms to any subaward, to the extent applicable to activities set out in such subaward.

Unallowable Costs:

- Research
- Clinical care
- Publicity and propaganda (lobbying):
    - Other than for normal and recognized executive-legislative relationships, no funds may be used for:
        - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
        - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
    - See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients: https://www.cdc.gov/grants/documents/Anti-Lobbying_Restrictions_for_CDC_Grantees_July_2012.pdf

- All unallowable costs cited in CDC-RFA-CK19-1904 remain in effect, unless specifically amended in this guidance, in accordance with 45 CFR Part 75 – Uniform Administrative Requirements, Cost Principles, And Audit Requirements for HHS Awards.

Budget Revision Requirement: By March 17, 2021 the recipient must submit a separate revised budget with a narrative justification and workplan in accordance with the COVID-19 guidance. The workplan should be submitted in REDCap and must address all activities in the guidance.

The revised budget and narrative justification must be uploaded as an amendment in Grant Solutions with a SF424A.

Failure to submit the required information in a timely manner may adversely affect the future funding of this project. If the information cannot be provided by the due date, you are required to contact the GMS/GMO identified in the CDC Staff Contacts section of this notice before the due date.

REPORTING REQUIREMENTS

COVID-19 - Additional Reporting Requirements:

- Monthly fiscal reports (beginning 60 days after NOAs are issued). Thereafter, all monthly financial reporting will occur on the 5th of the month which will cover the preceding month's expenditures and unliquidated obligations (ULOs).
- Quarterly workplan milestone progress reporting will start on April 30, 2021; and will follow the regular ELC quarterly reporting timeline.
- The Jurisdictional Testing, Case Investigation, and Contact Tracing Plan updates will occur on the same quarterly reporting timeline as the workplan milestone progress.
- CDC may require recipients to develop annual progress reports (APRs). CDC will provide APR guidance and optional templates should they be required

Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the following addresses:

CDC, [redacted]

Centers for Disease Control and
[redacted]
[redacted]@cdc.gov (Include “Mandatory Grant Disclosures” in subject line)

AND

U.S. Department of Health and Human Services
Office of the Inspector General
[redacted]
(Include “Mandatory Grant Disclosures” in subject line) or Email: MandatoryGranteeDisclosures@oig.hhs.gov

Recipients must include this mandatory disclosure requirement in all subawards and contracts under this award.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

CDC is required to report any termination of a federal award prior to the end of the period of performance due to material failure to comply with the terms and conditions of this award in the OMB-designated integrity and performance system accessible through SAM (currently FAPIIS). (45 CFR 75.372(b)) CDC must also notify the recipient if the federal award is terminated for failure to comply with the federal statutes, regulations, or terms and conditions of the federal award. (45 CFR 75.373(b))

PAYMENT INFORMATION

The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1- 800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, [redacted] Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a subaccount in the PMS, herein identified as the “P Account”. Funds must be used in support of approved activities in the

NOFO and the approved application.

The grant document number identified on the bottom of Page 1 of the Notice of Award must be known in order to draw down funds.

Stewardship Information

Stewardship: The recipient must exercise proper stewardship over Federal funds by ensuring that all costs charged to your cooperative agreement are allowable, allocable, and reasonable and that they address the highest priority needs as they relate to this program.

All the other terms and conditions issued with the original award remain in effect throughout the budget period unless otherwise changed, in writing, by the Grants Management Officer.

Exhibit K

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]

FAIN# [redacted]

Federal Award Date: 03/24/2025

Recipient Information

1. Recipient Name
PUBLIC HEALTH FOUNDATION ENTERPRISES, INC.
[redacted]
[NO DATA]

2. Congressional District of Recipient
32

3. Payment System Identifier (ID)
[redacted]

4. Employer Identification Number (EIN)
[redacted]

5. Data Universal Numbering System (DUNS)
[redacted]

6. Recipient's Unique Entity Identifier (UEI)
[redacted]

7. Project Director or Principal Investigator
[redacted]

8. Authorized Official
[redacted]

Federal Agency Information

CDC Office [redacted]

9. Awarding Agency Contact Information
[redacted]

10. Program Official Contact Information
[redacted]

Federal Award Information

11. Award Number
[redacted]

12. Unique Federal Award Identification Number (FAIN)
[redacted]

13. Statutory Authority
301(A)AND317(K)(2)PHS42USC241(A)247B(K)2

14. Federal Award Project Title
PHFE CDPH ELC 2019-2024

15. Assistance Listing Number
93.323

16. Assistance Listing Program Title
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

17. Award Action Type
Administrative Action

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 08/01/2023 **- End Date** 03/24/2025	
20.	**Total Amount of Federal Funds Obligated by this Action**	$0.00
	20a. Direct Cost Amount	$0.00
	20b. Indirect Cost Amount	$0.00
21.	Authorized Carryover	$38,507,520.00
22.	Offset	$3,546,390.00
23.	Total Amount of Federal Funds Obligated this budget period	$26,030,398.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$26,030,398.00
26.	**Period of Performance Start Date** 08/01/2019 **- End Date** 03/24/2025	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$3,392,957,047.50

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
[redacted]

30. Remarks

Department Authority

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]

FAIN# [redacted]

Federal Award Date: 03/24/2025

Recipient Information

Recipient Name

PUBLIC HEALTH FOUNDATION ENTERPRISES, INC.

[redacted]

[NO DATA]

Congressional District of Recipient

32

Payment Account Number and Type

[redacted]

Employer Identification Number (EIN) Data

[redacted]

Universal Numbering System (DUNS)

[redacted]

Recipient's Unique Entity Identifier (UEI)

[redacted]

31. Assistance Type

Cooperative Agreement

32. Type of Award

Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only

II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$25,724,697.00
b. Fringe Benefits	$8,568,846.00
c. Total Personnel Costs	$34,293,543.00
d. Equipment	$0.00
e. Supplies	$6,653,382.00
f. Travel	$501,398.00
g. Construction	$0.00
h. Other	$9,013,527.00
i. Contractual	$11,488,379.00
j. TOTAL DIRECT COSTS	**$61,950,229.00**
k. INDIRECT COSTS	**$6,134,079.00**
l. TOTAL APPROVED BUDGET	**$68,084,308.00**
m. Federal Share	**$68,084,308.00**
n. Non-Federal Share	**$0.00**

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	ASSISTANCE LISTING	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
[redacted]		CK	41.51	93.323	$0.00	[redacted]
		CK	41.51	93.323	$0.00	
		CK	41.51	93.323	$0.00	
		CK	41.51	93.323	$0.00	
		CK	41.51	93.323	$0.00	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Notice of Award

Centers for Disease Control and Prevention

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 03/24/2025

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

AWARD ATTACHMENTS

PUBLIC HEALTH FOUNDATION ENTERPRISES, INC. [redacted]

1. REVISED: TERMS AND CONDITIONS

TERMS AND CONDITIONS OF AWARD

Termination: The purpose of this amendment is to terminate the use of any remaining COVID-19 funding associated with this award. The termination of this funding is for cause. HHS regulations permit termination if "the non-Federal entity fails to comply with the terms and conditions of the award", or separately, "for cause." The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out. Termination of use of funding under the listed document number(s) is effective as of the date set out in your Notice of Award.

Impacted document numbers are included on page 2 of this Notice of Award (NoA).

No additional activities can be conducted, and no additional costs may be incurred, as it relates to these funds. Unobligated award balances of COVID-19 funding will be de-obligated by CDC. Award activities under other funding may continue consistent with the terms and conditions of the award.

Final Federal Financial Report (FFR, SF-425): Within 30 days please submit final FFR's for impacted document numbers. The FFR should only include those funds authorized and expended during the timeframe covered by the report. The final report must indicate the exact balance of unobligated funds and may not reflect any unliquidated obligations. Should the amount not match with the final expenditures reported to the Payment Management System (PMS), you will be required to update your reports to PMS accordingly.

All other terms and conditions of this award remain in effect.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]

FAIN# [redacted]

Federal Award Date: 03/25/2025

Recipient Information

1. Recipient Name
PUBLIC HEALTH FOUNDATION ENTERPRISES, INC.
[redacted]
[NO DATA]

2. Congressional District of Recipient
32

3. Payment System Identifier (ID)
[redacted]

4. Employer Identification Number (EIN)
[redacted]

5. Data Universal Numbering System (DUNS)
[redacted]

6. Recipient's Unique Entity Identifier (UEI)
[redacted]

7. Project Director or Principal Investigator
[redacted]

8. Authorized Official
[redacted]

Federal Agency Information
CDC Office of Financial Resources

9. Awarding Agency Contact Information
[redacted]

10. Program Official Contact Information
[redacted]

Federal Award Information

11. Award Number
[redacted]

12. Unique Federal Award Identification Number (FAIN)
[redacted]

13. Statutory Authority
301(A)AND317(K)(2)PHS42USC241(A)247B(K)2

14. Federal Award Project Title
PHFE CDPH ELC 2019-2024

15. Assistance Listing Number
93.323

16. Assistance Listing Program Title
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

17. Award Action Type
Administrative Action

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 08/01/2023 **- End Date** 07/31/2027	
20.	**Total Amount of Federal Funds Obligated by this Action**	$0.00
	20a. Direct Cost Amount	$0.00
	20b. Indirect Cost Amount	$0.00
21.	Authorized Carryover	$38,507,520.00
22.	Offset	$3,546,390.00
23.	Total Amount of Federal Funds Obligated this budget period	$26,030,398.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$26,030,398.00
26.	**Period of Performance Start Date** 08/01/2019 **- End Date** 07/31/2027	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$3,392,957,047.50

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
[redacted]

30. Remarks

This is an internal administrative action. No action is required from the recipient.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]

FAIN# [redacted]

Federal Award Date: 03/25/2025

Recipient Information

Recipient Name

PUBLIC HEALTH FOUNDATION ENTERPRISES, INC.

[redacted]

[NO DATA]

Congressional District of Recipient

32

Payment Account Number and Type

[redacted]

Employer Identification Number (EIN) Data

[redacted]

Universal Numbering System (DUNS)

[redacted]

Recipient's Unique Entity Identifier (UEI)

[redacted]

31. Assistance Type

Cooperative Agreement

32. Type of Award

Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only

II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$25,724,697.00
b. Fringe Benefits	$8,568,846.00
c. Total Personnel Costs	$34,293,543.00
d. Equipment	$0.00
e. Supplies	$6,653,382.00
f. Travel	$501,398.00
g. Construction	$0.00
h. Other	$9,013,527.00
i. Contractual	$11,488,379.00
j. TOTAL DIRECT COSTS	**$61,950,229.00**
k. INDIRECT COSTS	**$6,134,079.00**
l. TOTAL APPROVED BUDGET	**$68,084,308.00**
m. Federal Share	**$68,084,308.00**
n. Non-Federal Share	**$0.00**

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	ASSISTANCE LISTING	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
[redacted]		CK	41.51	93.323	$0.00	[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES Notice of Award

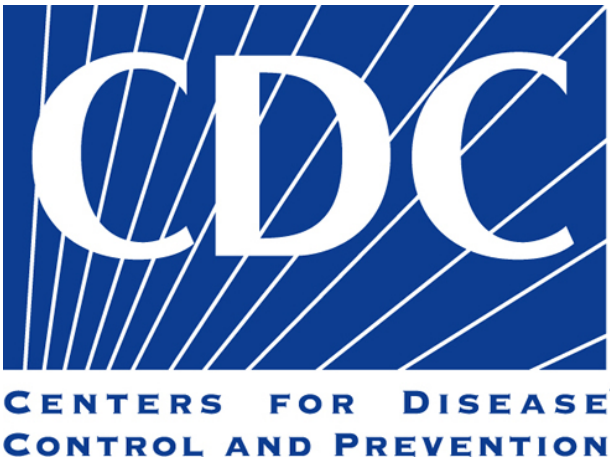
Centers for Disease Control and Prevention

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 03/25/2025

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

Exhibit L



Centers for Disease Control and Prevention

Office for State, Tribal, Local and Territorial Support

National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities

CDC [redacted]

05/03/2021

Table of Contents

Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-[redacted] Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC) / Agency for Toxic Substances and Disease Registry (ATSDR)

B. Notice of Funding Opportunity (NOFO) Title:

National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities

C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html (See section 45 CFR 46.102(d)).

D. Agency Notice of Funding Opportunity Number:

CDC[redacted]

E. Assistance Listings Number:

93.391

F. Dates:

1. Due Date for Letter of Intent (LOI):

03/26/2021

2. Due Date for Applications:
05/03/2021
11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:
CDC will host *two* informational conference calls for potential applicants:

Date: 03/30/2021

Times: 3:00pm to 4:00pm Eastern Standard Time
and
6:00pm to 7:00pm Eastern Standard Time

Meeting Details:
Join ZoomGov Meeting
https://cdc.zoomgov.com/j/16040976381?pwd=NmNjdFcrQlFVSjVPZ25nR0dHay9zdz09

Meeting ID: 160 4097 6381
Passcode: [redacted]
One tap mobile
+16692545252,,16040976381#,,,,,,0#,,708148093# US (San Jose)
+16468287666,,16040976381#,,,,,,0#,,708148093# US (New York)

Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
+1 669 216 1590 US (San Jose)
+1 551 285 1373 US
Meeting ID: 160 4097 6381
Passcode: [redacted]
Find your local number: https://cdc.zoomgov.com/u/advmPjIAqk

Join by SIP
16040976381@sip.zoomgov.com

Join by H.323
161.199.138.10 (US West)
161.199.136.10 (US East)
Meeting ID: 160 4097 6381
Passcode: [redacted]

G. Executive Summary:

1. Summary Paragraph
The *Consolidated Appropriations Act, 2021* (P.L. 116-260), which contained the *Coronavirus Response and Relief Supplemental Appropriations Act, 2021* (P.L. 116-260, Section 2, Division M) provided, in part, funding for strategies to improve testing capabilities and other COVID-19 response activities in populations that are at high-risk and underserved, including racial and

ethnic minority groups and people living in rural communities. Strategies also include those to develop or identify best practices for states and public health officials to use for contact tracing.

To achieve these purposes, the Centers for Disease Control and Prevention (CDC) is announcing a non-competitive grant CDC [redacted] titled "National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities." This grant will provide funding to address COVID-19 and advance health equity (e.g., through strategies, interventions, and services that consider systemic barriers and potentially discriminatory practices that have put certain groups at higher risk for diseases like COVID-19) in racial and ethnic minority groups and rural populations within state, local, US territorial, and freely associated state health jurisdictions.

a. Eligible Applicants:
Open Competition

b. Funding Instrument Type:
G (Grant)

c. Approximate Number of Awards
108

d. Total Period of Performance Funding:
$ 2,250,000,000
All funding will be disbursed during year one with a total performance period of two years.

e. Average One Year Award Amount:
$ 0
Funding will vary by jurisdiction category. Average one-year award amount by applicant type:

- State Health Department: $32,000,000
- Local Health Departments Serving a County or City with a Population of ≥2 Million: $26,000,000
- Local Health Departments Serving a City with a Population of 400,000 or more, but less than 2 Million: $5,000,000
- US Territories and Freely Associated States: $3,000,000

f. Total Period of Performance Length:
2

g. Estimated Award Date:
June 01, 2021

h. Cost Sharing and / or Matching Requirements:
No
Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

Coronavirus disease 2019 (COVID-19) has disproportionately affected populations placed at higher risk and who are medically underserved, including racial and ethnic minority groups, and people living in rural communities who are at higher risk of exposure, infection, hospitalization, and mortality. Additionally, racial and ethnic minority groups and people living in rural communities have disproportionate rates of chronic diseases that increase the severity of COVID-19 infection and might experience barriers to accessing testing, treatment, or vaccination against the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which causes COVID-19.

To reduce the burden of COVID-19 among populations disproportionately affected, it is imperative that state, local, US territorial, and freely associated state health departments (or their bona fide agents) work collaboratively and develop partnerships with key partners who have existing community or social service delivery programs for African American, Hispanic, Asian American, Pacific Islander, Native American or other racial and ethnic minority groups or people living in rural communities. Such key partners may include:

- Community-based and civic organizations;
- Tribes, tribal organizations;
- Academic institutions, and universities (e.g., minority serving institutions – Historically Black Colleges and Universities (HBCUs), Hispanic Association of Colleges and Universities (HACUs), American Indian Higher Education Consortium (AIHEC),Tribal Colleges and Universities (TCUs);
- Asian American and Pacific Islander Serving Institutions (AAPI);
- Faith-based organizations;
- Non-governmental organizations;
- Correctional facilities and institutions;
- Local governmental agencies and community leaders;
- Local businesses and business community networks and organizations, (e.g., employers, local chambers of commerce, small business community groups);
- Social services providers and organizations, including those that address social determinants of health (e.g., community transportation; anti-discrimination organizations; legal services);
- Health care providers, including community health centers (e.g., federally qualified health centers, (FQHCs);
- Health-related organizations, (e.g., pharmacies, testing centers, community health workers);
- State Offices of Rural Health (SORH) or equivalent, State Rural Health Associations (SRHAs);
- Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs); and
- Governmental organizations focused on non-health services (e.g., Coordinating Council on Access and Mobility – Department of Transportation, Supportive housing for the elderly – Housing and Urban Development).

To reach populations at higher risk, underserved, and disproportionately affected, including racial and ethnic minority groups and people living in rural communities, it is critical for funded recipients and key partners to implement a coordinated and holistic approach that builds on culturally, linguistically, and locally tailored strategies and best practices to reduce COVID-19 risk. In addition, a coordinated and holistic approach is essential to building and sustaining trust, ensuring equitable access to COVID-19 related services, and advancing health equity to address COVID-19 related health disparities among populations at higher risk, underserved, and disproportionately affected .[1]

b. Statutory Authorities

Section 317(k)(2) of the Public Health Service Act [42 USC 247b(k)(2), as amended] and the Consolidated Appropriations Act, 2021 (P.L. 116-260), which contained the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (P.L. 116-260, Section 2, Division M, Title III).

c. Healthy People 2030

This emergency funding opportunity focuses on emergency preparedness and response foundational capability and addresses the "*Healthy People 2030*" focus areas of Preparedness, Vaccination, Health Communication, Respiratory Disease, Infectious Disease, Public Health Infrastructure, and Social Determinants of Health.

For specific objectives within these topic areas, please visit www.healthypeople.gov.

d. Other National Public Health Priorities and Strategies

- Executive Order on Ensuring an Equitable Pandemic Response and Recovery (EO13995)
- Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (EO13985)
- National Strategy for the COVID-19 Response and Pandemic Preparedness (see Goal 6)
- CDC COVID-19 Response Health Equity Strategy: Accelerating Progress Towards Reducing COVID-19 Disparities and Achieving Health Equity
- Centers for Disease Control and Prevention Coronavirus 2019 (COVID-19) Recommendations and Guidance for state, local, territorial and tribal health departments

e. Relevant Work

This NOFO is complementary and non-duplicative of the following CDC program activities, public health priorities, and strategies:

- CDC-[redacted] Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC)
- ELC Enhancing Detection Emerging Issues (E) Project: Funding for the Enhanced Detection, Response, Surveillance, and Prevention of COVID-19 - Supplement
- CDC-RFA-OT18-1802: Strengthening Public Health Systems and Services Through National Partnerships to Improvement and Protect the Nation's Health

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

Due to the nature of this grant and public health crisis, there is not a predetermined logic model. It is expected that funds from this grant will be used to strengthen public health infrastructure, preparedness and response capabilities and services in state, local, US territorial and freely associated state health departments (or their bona fide agents) to address COVID-19 related health disparities and advance health equity in underserved and disproportionately affected populations through testing, contact tracing and other mitigation strategies. All applicants must define the populations disproportionately affected by COVID-19 within their respective jurisdiction, describe how they will reach these populations, and describe their experience working with communities that are underserved and at higher risk for COVID-19 disparities and health inequities.

Recipients will be required to include a financial carve out for rural communities, as applicable. As such, applicants who serve rural communities must define these communities and describe how they will provide direct support (e.g., funding, programs, or services) to those communities in their applications. State government applicants must also engage their State Office of Rural Health (SORH) or equivalent, in planning and implementing their activities and describe in their application how their SORHs or equivalent will be involved. To that end, CDC recommends state government applicants engage their respective SORH or equivalent, early in the application process. Contact information for SORHs can be found at: https://nosorh.org/nosorh-members/nosorh-members-browse-by-state/.

In addition, applicants are strongly encouraged to develop partnerships and collaborate with key partners who have existing community or social service delivery programs for African American, Hispanic, Asian American, Pacific Islander, Native American or other racial and ethnic minority groups or people living in rural communities. Such key partners may include:

- Community-based and civic organizations;
- Tribes, tribal organizations;
- Academic institutions, and universities (e.g., minority serving institutions – Historically Black Colleges and Universities (HBCUs), Hispanic Association of Colleges and Universities (HACUs), American Indian Higher Education Consortium (AIHEC),Tribal Colleges and Universities (TCUs);
- Asian American and Pacific Islander Serving Institutions (AAPI);
- Faith-based organizations;
- Non-governmental organizations;
- Correctional facilities and institutions;
- Local governmental agencies and community leaders;
- Local businesses and business community networks and organizations, (e.g., employers, local chambers of commerce, small business community groups);
- Social services providers and organizations, including those that address social determinants of health (e.g., community transportation; anti-discrimination organizations; legal services);
- Health care providers, including community health centers (e.g., federally qualified health centers, (FQHCs);

- Health-related organizations, (e.g., pharmacies, testing centers, community health workers);
- State Offices of Rural Health (SORH) or equivalent, State Rural Health Associations (SRHAs);
- Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs); and
- Governmental organizations focused on non-health services (e.g., Coordinating Council on Access and Mobility – Department of Transportation, Supportive housing for the elderly – Housing and Urban Development).

Through this collaborative approach, applicants will be better able to maximize the impact of their federal COVID-19 funding, strengthen implementation of strategies and activities, and align resources to better match the burden of COVID-19 among populations who are at higher risk and are underserved. This collaboration must be described in the application.

Applicants are encouraged to establish new funding relationships with partners and community organizations and may also continue funding relationships with partners and community organizations that have experience working with communities most affected by COVID-19 and have the capacity to implement strategies and activities outlined in this NOFO. To ensure resources reach the areas of greatest need, all applicants are strongly encouraged to use local epidemiologic, surveillance, and other available data sources to inform local resource allocation and program efforts, including program planning, implementation, and evaluation.

i. Purpose

Address COVID-19-related health disparities and advance health equity by expanding state, local, US territorial and freely associated state health department capacity and services to prevent and control COVID-19 infection (or transmission) among populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities.

ii. Outcomes

The intended outcomes for this grant are:

1. Reduced COVID-19-related health disparities.
2. Improved and increased testing and contact tracing among populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities.
3. Improved state, local, US territorial and freely associated state health department capacity and services to prevent and control COVID-19 infection (or transmission) among populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities.

iii. Strategies and Activities

This grant program will address COVID-19-related health disparities and advance health equity by expanding state, local, US territorial and freely associated state health department capacity and services to prevent and control COVID-19 infection (or transmission) among populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities. All strategies should aim to build infrastructures that both address disparities in the current COVID-19 pandemic and set the foundation to address future responses.

The program is composed of *four* overarching strategies:

1. Expand existing and/or develop new mitigation and prevention resources and services to reduce COVID-19 related disparities among populations at higher risk and that are underserved: Ensuring equitable access to critical COVID-19 personal protective equipment (PPE), testing, contact tracing, quarantine and isolation, vaccination, and other wrap-around services require deploying focused strategies, resources, and activities to meet the needs of individuals and mitigate the spread of COVID-19 among populations disproportionately impacted.
Priority activities for *Strategy 1* should include:

- Expand testing (including home test kits and mobile testing sites) and contact tracing among populations at higher risk and that are underserved, including racial and ethnic minority populations and people living in rural communities;

Additional activities may include but are not limited to:

- Vaccine coordination, quarantine and isolation options, and preventive care and disease management among populations that are underserved and at higher risk for COVID-19
- Tailor and adapt evidence-based policies, systems, and environmental strategies to mitigate social and health inequities related to COVID-19
- Identify and establish collaborations with critical partners affiliated with populations at higher risk and that are underserved, including racial and ethnic minority groups at higher risk for COVID-19 to:1) connect community members to programs, healthcare providers, services and resources (e.g., transportation, housing support, food assistance programs, mental health and substance abuse services, substance abuse) they might need and 2) lessen adverse effects of mitigation strategies

2. Increase/improve data collection and reporting for populations experiencing a disproportionate burden of COVID-19 infection, severe illness, and death to guide the response to the COVID-19 pandemic: Improving data systems and the collection, analysis, and use of racial, ethnic, and rural health data for COVID-19 prevention and control will help to better identify populations and communities disproportionately affected, track resource distribution, and evaluate the effectiveness of advancing health equity to address COVID-19-related health disparities among disproportionately affected populations. Collection of data that contextualize racial, ethnic, and rural health data and robust analysis of these data are fundamental activities for improving data collection and reporting.

Priority activities for *Strategy 2* should include:

- Improve data collection and reporting for testing and contact tracing for populations at higher risk and that are underserved;

Additional activities may include but are not limited to:

- Build on plans for collecting and reporting timely, complete, representative, and relevant data on testing, incidence, vaccination, and severe outcomes by detailed race and ethnicity categories, taking into account age and sex differences between groups

- Develop strategies to educate providers, community partners, and programs on: 1) the importance of the race and ethnicity data and appropriate strategies to collect it: 2) how to address mistrust/hesitancy about reporting personal information including race and ethnicity, and 3) why this information is important to prevent and control the spread of COVID-19
- Develop and implement plans to disseminate health equity-related data and related materials tailored to be culturally and linguistically responsive for diverse audiences
- Develop key principles and resources for collecting, analyzing, reporting, and disseminating health equity-related data to inform action during a public health emergency
- Assure adequate resources for data infrastructure and workforce to ensure alignment with data modernization

3. Build, leverage, and expand infrastructure support for COVID-19 prevention and control among populations that are at higher risk and underserved: Sufficient workforce, infrastructure, and capacity are critical to providing equitable access to disproportionately affected populations. Where feasible, this short-term program will build, leverage, and expand the infrastructure and capacity within state, local, US territorial and freely associated state health departments (or their bona fide agents) to ensure and expand equitable access to critical COVID-19 testing and contact tracing, as well as PPE, quarantine and isolation, vaccination, and other wrap-around and supportive services.
Priority activities for *Strategy 3* should include:

- Expand the infrastructure to improve testing and contact tracing among populations at higher risk and that are underserved, including racial and ethnic minority populations and rural communities;

Additional activities may include but are not limited to:

- Establish, enhance, or implement leadership-level health equity offices, workgroups, task forces, or positions to guide addressing COVID-19 among communities at higher risk and that are underserved
- Convene and facilitate multi-sector coalitions or advisory groups that include members of underserved communities and organizations that serve the community. These groups may provide advice, guidance, and recommendations for addressing COVID-19 and advancing health equity among their communities
- Update jurisdictions' COVID-19 plans and health equity plans to support communities most at risk for COVID-19 with the intention of setting up systems that put in place infrastructures and plans that can also support future emergency responses
- Build and expand an inclusive public health workforce, including hiring people from the community (e.g., community health workers, social workers, other trusted community members) who are equipped to assess and address the needs of communities disproportionately affected by COVID-19

4. Mobilize partners and collaborators to advance health equity and address social determinants of health as they relate to COVID-19 health disparities among populations at higher risk and that are underserved: Identifying and addressing current gaps and factors that influence COVID-19-related health disparities requires a collaborative approach. Under this

strategy, collaborations between the primary applicant and key partners will broadly address health disparities and inequities related to COVID-19. (Please refer to Approach section of NOFO for a list of recommended key partners.)
Priority activities for Strategy 4 should include:

- Build community capacity to reach disproportionately affected populations with effective culturally and linguistically tailored programs and practices for testing and contact tracing, and quarantine, including racial and ethnic minority populations and rural communities;

Additional activities may include but are not limited to:

- Build and implement cross-sectoral partnerships to align public health, healthcare, and non-health (e.g., housing, transportation, social service) interventions that decrease risk for COVID-19
- Develop mechanisms such as community advisory groups that include leaders representing racial and ethnic minority groups and rural community leaders and members representing underserved populations to inform COVID-19 and future emergency response activities
- Develop and disseminate culturally and linguistically responsive COVID-19 prevention communications through various channels (e.g., local media, local or community newspapers, radio, TV, trusted communications agents) written in plain language and in formats and languages suitable for diverse audiences—including people with disabilities, limited English proficiency, etc.—addressing and, as necessary, dispelling of misinformation and barriers to mitigation practices due to mistrust.
- Build community capacity that includes traditional organizations (e.g., public health, healthcare) and non-traditional partners (e.g., community health workers, churches, transportation providers, social workers) to reach disproportionately affected populations with effective culturally and linguistically tailored programs and practices for testing, contact tracing, isolating, vaccination, and healthcare strategies
- Identify and establish collaborations with critical partners affiliated with and who provide services to populations that are underserved and at higher risk for COVID-19 to disseminate scientifically accurate, culturally, and linguistically responsive information and facilitate access to health-related services

Applicants are not required to implement all four strategies, but rather they should select the strategies and activities that best address their jurisdiction's respective priorities and needs. Strategies should engage representatives of populations and communities to be served by this NOFO. CDC will also allow applicants to propose additional strategies and activities beyond those included in the NOFO to best achieve local outcomes. Any proposed new strategy or activity should include the rationale for the approach or a brief justification with evidence showing why it should be included. Applicants should not propose to allocate all funding to one activity (e.g. all funding will be used for one vaccination or testing event only).

1. Collaborations

a. With other CDC programs and CDC-funded organizations:

Recipients are encouraged to collaborate, as appropriate, with CDC programs and centers, institutes, and offices (CIOs) to ensure that activities and funding are coordinated with, complementary of, and not duplicative of efforts supported under other CDC programs that support COVID-19 response.

To facilitate the identification and sharing of best practices, program evaluation, training, tool development, and communications of findings, recipients may receive tailored technical assistance from select national or regional partner organizations funded through CDC-RFA-OT18-1802: *Strengthening Public Health Systems and Services through National Partnerships to Improvement and Protect the Nation's Health.*

For questions about collaborating with CDC, please contact the CDC point of contact for this NOFO.

b. With organizations not funded by CDC:
It is a requirement of this opportunity to include a financial carve out for rural communities, as applicable. As such, applicants who serve rural communities must define these communities and describe how they will provide direct support (e.g., funding, programs and/or services) to those communities. State government applicants must also engage their State Office of Rural Health (SORH) or equivalent, in planning and implementing their activities and describe in their application how their SORHs or equivalent will be involved. To that end, CDC recommends state government applicants engage their respective SORH or equivalent, early in the application process. Contact information for SORHs can be found at: https://nosorh.org/nosorh-members/nosorh-members-browse-by-state/.

In addition, applicants are strongly encouraged to develop partnerships and collaborate with key partners who have existing community or social service delivery programs for African American, Hispanic, Asian American, Pacific Islander, Native American or other racial and ethnic minority groups or people living in rural communities. Such key partners may include:

- Community-based and civic organizations;
- Tribes, tribal organizations;
- Academic institutions, and universities (e.g., minority serving institutions – Historically Black Colleges and Universities (HBCUs), Hispanic Association of Colleges and Universities (HACUs), American Indian Higher Education Consortium (AIHEC),Tribal Colleges and Universities (TCUs);
- Asian American and Pacific Islander Serving Institutions (AAPI);
- Faith-based organizations;
- Non-governmental organizations;
- Correctional facilities and institutions;
- Local governmental agencies and community leaders;
- Local businesses and business community networks and organizations, (e.g., employers, local chambers of commerce, small business community groups);
- Social services providers and organizations, including those that address social determinants of health (e.g., community transportation; anti-discrimination organizations; legal services);

- Health care providers, including community health centers (e.g., federally qualified health centers, (FQHCs);
- Health-related organizations, (e.g., pharmacies, testing centers, community health workers);
- State Offices of Rural Health (SORH) or equivalent, State Rural Health Associations (SRHAs);
- Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs); and
- Governmental organizations focused on non-health services (e.g., Coordinating Council on Access and Mobility – Department of Transportation, Supportive housing for the elderly – Housing and Urban Development).

Through this collaborative approach, applicants will be better able to maximize the impact of their federal COVID-19 funding, strengthen implementation of strategies and activities, and align resources to better match the burden of COVID-19 among populations who are at higher risk and are underserved. This collaboration must be described in the application.

Applicants are encouraged to establish new funding relationships with partners and community organizations and may also continue funding relationships with partners and community organizations that have experience working with communities most affected by COVID-19 and have the capacity to implement strategies and activities outlined in this NOFO. To ensure resources reach the areas of greatest need, all applicants are strongly encouraged to use local epidemiologic, surveillance, and other available data sources to inform local resource allocation and program efforts, including program planning, implementation, and evaluation.

Memoranda of understanding (MOUs) or memoranda of agreement (MOAs) are encouraged, but not required.

2. Target Populations

This NOFO relates specifically to populations that have been placed at higher risk and are underserved, which, depending on the needs and priorities of the applicant, may include African American, Latino, and Indigenous and Native American people, Asian Americans and Pacific Islanders, and other people of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people; people with disabilities; people who live in rural communities; people over the age of 65, and people otherwise adversely affected by persistent poverty or inequality.

Recipients are required to define and describe their respective population(s) of focus and describe how they will provide direct support (e.g., funding, services, or programs) to those communities within their application. Please include in the description the number of those you will serve broken out by applicable geographic area and/or community.

Recipients are also encouraged to include members of the populations and communities to be served in the planning, implementation, and evaluation of program activities.

a. Health Disparities

Evidence shows that COVID-19-related health disparities are inextricably linked to complex and widespread health and social inequities that have put many people from populations that are underserved —including racial and ethnic minority groups and people living in rural communities—at higher risk of exposure, infection, hospitalization, and mortality from COVID-19.[2, 3, 4] Health equity requires striving for the highest possible standard of health for all people, giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

The intent of this funding opportunity is to address COVID-19-related health disparities and advance health equity by expanding state, local, US territorial and freely associated state health department capacity and services to prevent and control COVID-19 infection (or transmission) among populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities.

To reduce the burden of COVID-19 among disproportionately affected populations applicants are strongly encouraged to develop partnerships and collaborate with key partners who have existing community or social service delivery programs for African American, Hispanic, Asian American, Pacific Islander, Native American or other racial and ethnic minority groups or people living in rural communities. Such key partners may include:

- Community-based and civic organizations;
- Tribes, tribal organizations;
- Academic institutions, and universities (e.g., minority serving institutions – Historically Black Colleges and Universities (HBCUs), Hispanic Association of Colleges and Universities (HACUs), American Indian Higher Education Consortium (AIHEC),Tribal Colleges and Universities (TCUs);
- Asian American and Pacific Islander Serving Institutions (AAPI);
- Faith-based organizations;
- Non-governmental organizations;
- Correctional facilities and institutions;
- Local governmental agencies and community leaders;
- Local businesses and business community networks and organizations, (e.g., employers, local chambers of commerce, small business community groups);
- Social services providers and organizations, including those that address social determinants of health (e.g., community transportation; anti-discrimination organizations; legal services);
- Health care providers, including community health centers (e.g., federally qualified health centers, (FQHCs);
- Health-related organizations, (e.g., pharmacies, testing centers, community health workers);
- State Offices of Rural Health (SORH) or equivalent, State Rural Health Associations (SRHAs);
- Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs); and

- Governmental organizations focused on non-health services (e.g., Coordinating Council on Access and Mobility – Department of Transportation, Supportive housing for the elderly – Housing and Urban Development).

To reach populations at higher risk, underserved, and disproportionately affected—including racial and ethnic minority groups, and people living in rural communities—it is critical for funded recipients and key partners to implement a coordinated and holistic approach that builds on culturally, linguistically, and locally tailored strategies and best practices to reduce COVID-19 risk. In addition, a coordinated and holistic approach is essential to build and sustain trust, ensure equitable access to COVID-19-related services, and advance health equity to address COVID-19-related health disparities among populations at higher risk, underserved, and disproportionately affected.

iv. Funding Strategy

The funding strategy will consist of three components aimed at decreasing health disparities. The components are defined by type of jurisdiction. The amount of funds available for each component are based on the overall population size for each type of jurisdiction. Funds will be awarded for each component using a separate formula that is: a) consistent with the intent of the legislation and purposes of the grant, and b) appropriate for the eligible recipients. The three jurisdiction-specific components include:

1. State, City and County Jurisdictions: Approximately 80% of total available funding will be awarded to all states and eligible cities and counties based on COVID-19 social and structural determinants, as defined by the COVID-19 Community Vulnerability Index (CCVI).
2. Rural Jurisdictions: Approximately 19% of total available funding will be awarded to states with rural populations, as defined by the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP) definition of rural. All state recipients will receive a portion of the rural funding available. Each recipient's share will be based on the size of the rural population within the recipient's jurisdiction. These funds will be distributed to state recipients in combination with the first Component (i.e., the CCVI allotment, in a single award.)
3. US Territorial and Freely Associated State Jurisdictions: Approximately 1% of total available funds will be awarded to US territories and freely associated states. Each US territorial and freely associated state recipient will receive base funding ($500,000), plus a population-based allotment that has been adjusted for COVID-19 burden. The COVID-19 burden adjustment will be based on the cumulative number of cases and deaths (per 100,000) for each US territory and freely associated state.

Please see Attachment A: [redacted] List of Eligible Applicants for a complete list of eligible applicants.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

Performance measures will be finalized and provided to recipients within approximately 45 days of award.

CDC will use recipients' financial and progress reporting data to address evaluation questions relating to use of funds and results associated with the grant. CDC will collect this information quarterly through the end of the period of performance utilizing standardize templates. Quarterly expenditure and progress reports will be submitted via the Research Electronic Data Capture, or otherwise known as REDCap. CDC will provide training and technical assistance for recipients on REDCap post-award.

Given the flexible nature of this grant and diversity of allowable activities, a Data Management Plan (DMP) is not required **unless** a recipient chooses to allocate funding to a COVID-19 activity that involves the collection, generation, or analysis of data. The DMP may be submitted as a checklist, paragraph, or other format. To help guide applicants in developing a DMP, a sample plan is provided via the following link:
http://www.icpsr.umich.edu/icpsrweb/content/datamanagement/dmp/plan.html

As a result of the declared public health emergency (PHE), COVID-19, CDC's COVID-19 related data collections currently fall under a PHE Paperwork Reduction Act (PRA) Waiver as part of the 21st Century Cures Act. PRA requirements for most information collection activities that support the investigation of, and response to the COVID-19 pandemic, that would normally require submission of a PRA package, can be waived. If information collection activities continue beyond the period of the declared public health emergency or beyond the termination PHE PRA Waiver, all collections will become subject to requirements of the PRA. Awardees will receive additional guidance from CDC on how to address these PRA requirements.

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How the applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, the applicant should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

Due to the nature of this grant and public health crisis, applicants are not required to provide an Evaluation and Performance Measurement plan with their application. Recipients are strongly encouraged to use evaluation and performance measurement data at the local level to monitor, evaluate, and continuously improve program performance. CDC will finalize and provide performance measures within approximately 45 days of award. Recipients will be required to report quarterly on CDC defined performance measures and participate in CDC evaluation and performance management activities. Evaluation reports will be made available to the public.

c. Organizational Capacity of Recipients to Implement the Approach

Applicants must demonstrate the organizational capacity needed to carry out and coordinate strategies to advance health equity and address COVID-19-related health disparities for populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities.

Applicants must also demonstrate the capacity to collaborate with their State Offices of Rural Health (SORH) or equivalent, if applicable, and with key partners with community or social service delivery programs for African American, Hispanic, Asian American, Pacific Islander, Native American or other racial and ethnic minority groups or people living in rural communities. Please refer to Approach section of NOFO for a list of recommended key partners.

Acceptable documentation includes, but is not limited to, a signed letter by the health department leader or their designees on organization letterhead explaining the existing capacity and capability; departmental organizational charts; an incident management structure organizational chart; and resumes or CVs for key personnel positions that are currently filled (include position descriptions for vacant positions). Applicant must name this file “Organizational Capacity” and upload it as a PDF to www.grants.gov.

d. Work Plan

Applicants must develop and submit a high-level work plan for the 2-year period of performance. The work plan must align with the strategies and activities outlined in the NOFO. Specifically, activities must align to one or more of the following strategies:

- *Strategy 1:Expand existing and/or develop new mitigation and prevention resources and services to reduce COVID-19 related disparities among populations at higher risk and that are underserved*

- *Strategy 2: Increase/improve data collection and reporting for populations experiencing a disproportionate burden of COVID-19 infection, severe illness, and death to guide the response to the COVID-19 pandemic*
- *Strategy 3: Build, leverage, and expand infrastructure support for COVID-19 prevention and control among populations that are at higher risk and underserved*
- *Strategy 4: Mobilize partners and collaborators to advance health equity and address social determinants of health as they relate to COVID-19 health disparities among populations at higher risk and that are underserved*

Applicants are not required to implement all four strategies, but rather they should select the strategies and activities that best address their jurisdiction's respective priorities and needs. Strategies should engage representatives of populations and communities to be served by this NOFO. CDC will also allow applicants to propose additional strategies and activities beyond those included in the NOFO to best achieve local outcomes. Any proposed new strategy or activity should include the rationale for the approach or a brief justification with evidence showing why it should be included. Applicants should not propose to allocate all funding to one activity (e.g. all funding will be used for one vaccination or testing event only).

Applicants must use the template provided as Attachment B: CDC-[redacted] Work Plan Template. Applicant must name this file "[Name of Jurisdiction] Work Plan" and upload it as an attachment to www.grants.gov.

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities deemed necessary to monitor the award:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk recipients.

CDC will collect recipient financial and progress reporting data quarterly through the end of the period of performance.

CDC will also conduct a virtual compliance visit after six months, but before the end of the first year, from date of the award. The virtual compliance visit will be a telephone call and/or video conference to ensure the recipient's compliance with using the funding for the approved activities and to identify technical assistance needs. CDC may conduct additional in-person site or virtual visits as needed to best facilitate grants management and oversight duties.

B. Award Information

1. Funding Instrument Type:
G (Grant)

2. Award Mechanism:
CDC-[redacted]

3. Fiscal Year:
2021

4. Approximate Total Fiscal Year Funding:
$ 2,250,000,000

5. Total Period of Performance Funding:
$ 2,250,000,000
This amount is subject to the availability of funds.

All funding will be disbursed during year one with a total performance period of two years.

Estimated Total Funding:
$ 2,250,000,000

6. Total Period of Performance Length:
2
year(s)

7. Expected Number of Awards:
108

8. Approximate Average Award:

$ 0
Per Project Period

Funding will vary by jurisdiction category. Average one-year award amount by applicant type:

- State Health Department: $32,000,000
- Local Health Departments Serving a County or City with a Population of ≥2 Million: $26,000,000

- Local Health Departments Serving a City with a Population of 400,000 or more, but less than 2 Million: $5,000,000
- US Territories and Freely Associated States: $3,000,000

9. Award Ceiling:
$ 50,000,000
Per Project Period

This amount is subject to the availability of funds.

Funding will vary by jurisdiction category. Award Ceiling by applicant type:

- State Health Department: $50,000,000
- Local Health Departments Serving a County or City with a Population of ≥2 Million: $35,000,000
- Local Health Departments Serving a City with a Population of 400,000 or more, but less than 2 Million: $9,000,000
- US Territories and Freely Associated States: $10,000,000

10. Award Floor:
$ 500,000
Per Project Period

Funding will vary by jurisdiction category. Award Floor by applicant type:

- State Health Department: $17,000,000
- Local Health Departments Serving a County or City with a Population of ≥2 Million: $17,000,000
- Local Health Departments Serving a City with a Population of 400,000 or more, but less than 2 Million: $2,000,000
- US Territories and Freely Associated States: $500,000

11. Estimated Award Date:
June 01, 2021

12. Budget Period Length:
24 month(s)

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (project period) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance

Direct Assistance (DA) is not available through this NOFO.

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:
00 (State governments)

01 (County governments)

02 (City or township governments)

04 (Special district governments)

25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

Additional Eligibility Category:

Government Organizations:

State governments or their bona fide agents (includes the District of Columbia)

Local governments or their bona fide agents

Territorial governments or their bona fide agents in the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau

2. Additional Information on Eligibility

Awards must be made to state, District of Columbia, local, US territorial, and/or freely associated state health departments (or their bona fide agents). Local (health departments) governments or their bona fide agents are eligible if they:

- Serve a county population of 2,000,000 or more; or serve a city population of 400,000 or more. Population for county and city jurisdictions are based on the following US Census 2019 resources:
    - City and Town Population Totals: 2010-2019 (census.gov) U.S. Census -- Annual Estimates of the Resident Population for Incorporated Places of 50,000 or More, Ranked by July 1, 2019 Population: April 1, 2010 to July 1, 2019
    - County Population Totals: 2010-2019 (census.gov)- US Census – Annual Estimates for 2019

Bona fide agents are eligible to apply. For more information about bona fide agents, please see the CDC webpage on Expediting the Federal Grant Process with an Administrative Partner located at https://www.cdc.gov/publichealthgateway/grantsfunding/expediting.html#Q2

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:
No
Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Application and Submission Information

1. Required Registrations

An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

a. Data Universal Numbering System:
All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for federal awards or cooperative agreements.
The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or internet at http:// fedgov.dnb. com/ webform/ displayHomePage.do. The DUNS number will be provided at no charge.
If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their DUNS numbers before accepting any funds.

b. System for Award Management (SAM):
The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at https://www.sam.gov/SAM/.

c. Grants.gov:
The first step in submitting an application online is registering your organization at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option at www.grants.gov.
All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants should start the registration

process as early as possible.

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http:// fedgov.dnb.com/ webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instructions to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http:// fedgov.dnb.com/ webform) or call 1-866-705-5711
2	System for Award Management (SAM) formerly Central Contractor Registration (CCR)	1. Retrieve organizations DUNS number 2. Go to https://www.sam.gov/SAM/ and designate an E-Biz POC (note CCR username will not work in SAM and you will need to have an active SAM account before you can register on grants.gov)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/ fsd-gov/ home.do Calls: 866-606-8220
3	Grants.gov	1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	Same day but can take 8 weeks to be fully registered and approved in the system (note, applicants MUST obtain a DUNS number and SAM account before applying on grants.gov)	Register early! Log into grants.gov and check AOR status until it shows you have been approved

2. Request Application Package

Applicants may access the application package at www.grants.gov.

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this notice of funding opportunity at www.grants.gov.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by OGS.

a. Letter of Intent Deadline (must be emailed or postmarked by)

Due Date for Letter Of Intent 03/26/2021

03/26/2021

b. Application Deadline

05/03/2021

11:59 pm U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Due Date for Information Conference Call

CDC will host *two* informational conference calls for potential applicants:

Date: 03/30/2021

Times: 3:00pm to 4:00pm Eastern Standard Time
and
6:00pm to 7:00pm Eastern Standard Time

Meeting Details:
Join ZoomGov Meeting
https://cdc.zoomgov.com/j/16040976381?pwd=NmNjdFcrQlFVSjVPZ25nR0dHay9zdz09

Meeting ID: 160 4097 6381
Passcode: [redacted]
One tap mobile
+16692545252,,16040976381#,,,,,,0#,,708148093# US (San Jose)
+16468287666,,16040976381#,,,,,,0#,,708148093# US (New York)

Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
+1 669 216 1590 US (San Jose)
+1 551 285 1373 US
Meeting ID: 160 4097 6381

Passcode: [redacted]
Find your local number: https://cdc.zoomgov.com/u/advmPjIAqk

Join by SIP
16040976381@sip.zoomgov.com

Join by H.323
161.199.138.10 (US West)
161.199.136.10 (US East)
Meeting ID: 160 4097 6381
Passcode: [redacted]

5. CDC Assurances and Certifications

All applicants are required to sign and submit "Assurances and Certifications" documents indicated at http://wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa)) /Homepage.aspx.

Applicants may follow either of the following processes:

- Complete the applicable assurances and certifications with each application submission, name the file "Assurances and Certifications" and upload it as a PDF file with at www.grants.gov
- Complete the applicable assurances and certifications and submit them directly to CDC on an annual basis at http://wwwn.cdc.gov/ grantassurances/ (S(mj444mxct51lnrv1hljjjmaa))/ Homepage.aspx

Assurances and certifications submitted directly to CDC will be kept on file for one year and will apply to all applications submitted to CDC by the applicant within one year of the submission date.

Risk Assessment Questionnaire Requirement

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with

supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and DUNS.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

Duplication of Efforts

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.

Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

6. Content and Form of Application Submission

Applicants are required to include all of the following documents with their application package at www.grants.gov.

7. Letter of Intent

Letters of Intent (LOI) are not required but are requested as part of the application for this NOFO. The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications.

Letters of Intent should be submitted via email to [redacted]@cdc.gov no later than March 26, 2021.

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package.

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)

Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

a. Background

Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

b. Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the public health problem as described in the CDC Background section.

ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period, as identified in the logic model in the Approach section of the CDC Project Description. Outcomes are the results that the program intends to achieve and usually indicate the intended direction of change (e.g., increase, decrease).

iii. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the period of performance outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan how these strategies will be evaluated over the course of the project period. See the Strategies and Activities section of the CDC Project Description.

1. Collaborations

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants must address the Collaboration requirements as described in the CDC Project Description.

2. Target Populations and Health Disparities

Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC's requirements under PRA see http://www.hhs.gov/ ocio/policy/collection/.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

d. Organizational Capacity of Applicants to Implement the Approach

Applicants must address the organizational capacity requirements as described in the CDC Project Description.

11. Work Plan

(Included in the Project Narrative's page limit)

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

Applicants must submit an itemized budget narrative. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file "Budget Narrative" and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

13. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub

accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 45 CFR 75 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

14. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 Code of Federal Regulations (CFR) section 3.908 to the award and requires that recipients inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

15. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS

identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

16. Funding Restrictions

Restrictions that must be considered while planning the programs and writing the budget are:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
    - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
    - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

Coronavirus Disease 2019 (COVID-19) Funds:

- A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the "CARES Act") (P.L. 116-136); the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139); and/or H.R. 133 - Consolidated Appropriations Act, 2021, Division M – Coronavirus Response and Relief Supplemental Appropriations Act, 2021, agrees, as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health

measures (e.g., social distancing, home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation.

- In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS–CoV–2 or to diagnose a possible case of COVID–19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC. HHS laboratory reporting guidance is posted at: https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf.
- Further, consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the purpose of this award, and the underlying funding, the recipient is expected to provide to CDC copies of and/or access to COVID-19 data collected and evaluations conducted with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.
- To achieve the public health objectives of ensuring the health, safety, and welfare of all Americans, Recipient must distribute or administer vaccine without discriminating on non-public-health grounds within a prioritized group.

18. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information:
https://www.cdc.gov/grants/additionalrequirements/ar-25.html

18. Other Submission Requirements

a. Electronic Submission:

Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

b. Tracking Number: Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant's Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the NOFO. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Grants.gov Online User Guide.

https:// www.grants.gov/help/html/help/index.htm? callingApp=custom#t= Get_Started%2FGet_Started. htm

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at [redacted] or by e-mail at support@grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at [redacted] or e-mail them at support@grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.

An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered.

   If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Review and Selection Process

1. Review and Selection Process: Applications will be reviewed in three phases

a. Phase 1 Review

All applications will be initially reviewed for eligibility and completeness by CDC Office of Grants Services. Complete applications will be reviewed for responsiveness by the Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.

i. Approach
ii. Evaluation and Performance Measurement
iii. Applicant's Organizational Capacity to Implement the Approach

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements

i. Approach	**Maximum Points:** 0
ii. Evaluation and Performance Measurement	**Maximum Points:** 0
iii. Applicant's Organizational Capacity to Implement the Approach	**Maximum Points:** 0
Budget	**Maximum Points:** 0
i. Approach	**Maximum Points:** 0
ii. Evaluation and Performance Measurement	**Maximum Points:** 0
iii. Applicant's Organizational Capacity to Implement the Approach	**Maximum Points:** 0
Budget	**Maximum Points:** 0

c. Phase III Review

This is a noncompetitive NOFO. Applications will be reviewed for technical merit without scoring.

Review of risk posed by applicants.

Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold,

defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

(1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

The anticipated posting date is March 17, 2021, on www.grants.gov. Applicants will have up to 45 days, or May 3, 2021, to respond. Applicants are encouraged to apply early. The anticipated award date is approximately 30 calendar days after the end of the application period, or June 1, 2021.

F. Award Administration Information

1. Award Notices

Recipients will receive an electronic copy of the Notice of Award (NOA) from CDC OGS. The NOA shall be the only binding, authorizing document between the recipient and CDC. The NOA will be signed by an authorized GMO and emailed to the Recipient Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to the DUNS, SAM Registration, and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt or by U.S. mail.

2. Administrative and National Policy Requirements

The following Administrative Requirements (AR) apply to this NOFO:

- *AR-7: Executive Order 12372 Review*
- *AR-8: Public Health System Reporting Requirements*
- *AR-9: Paperwork Reduction Act Requirements*
- *AR-10: Smoke-Free Workplace Requirements*
- *AR-11: Healthy People 2030*
- *AR-12: Lobbying Restrictions*
- *AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities*
- *AR-8: Public Health System Reporting Requirements*
- *AR-15: Proof of Non-profit Status*
- *AR-23: Compliance with 45 CFR Part 87*
- *AR-14: Accounting System Requirements*
- *AR-16: Security Clearance Requirement*
- *AR-21: Small, Minority, And Women-owned Business*
- *AR-24: Health Insurance Portability and Accountability Act Requirements*
- *AR-25: Data Management and Access*
- *AR-26: National Historic Preservation Act of 1966*
- *AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving", October 1, 2009*
- *AR-30: Information Letter 10-006, - Compliance with Section 508 of the Rehabilitation Act of 1973*
- *AR-32: Enacted General Provisions*
- *AR-34: Language Access for Persons with Limited English Proficiency*
- *AR-37: Prohibition on certain telecommunications and video surveillance services or equipment for all awards issued on or after August 13, 2020*

Recipients are also expected to adhere to administrative requirements relating to nondiscrimination contained in Standard Form 424B (Rev. 7-97): Assurances - Non-Construction Programs, prescribed by OMB Circular A-102.

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75

3. Reporting

Reporting provides continuous program monitoring and identifies successes and challenges that recipients encounter throughout the project period. Also, reporting is a requirement for recipients who want to apply for yearly continuation of funding. Reporting helps CDC and recipients because it:

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables CDC to assess the overall effectiveness and influence of the NOFO.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the "Agency Contacts" section of the NOFO copying the CDC Project Officer.

Report Type	When?	Required?
Expenditure Reporting	Quarterly expenditure reports are due 60 days into the award and at the end of each fiscal quarter thereafter through the period of performance.	Yes
Payment Management System (PMS) Reporting	Quarterly reports are due 60 days into the award and at the end of each fiscal quarter thereafter through the period of performance.	Yes
Progress Reporting	Quarterly progress reports are due 6o days into the award and at the end of each fiscal quarter thereafter through the period of performance.	Yes
Federal Financial Reporting Forms	Due 90 days after the end of the budget period	Yes
Final Performance and Financial Report	Due 90 days after end of period of performance	Yes

There may be flexibility in reporting deadlines. CDC will communicate updates or revisions to reporting requirements as appropriate.

Quarterly expenditure and progress reports will be submitted via the Research Electronic Data Capture, or otherwise known as REDCap. CDC will provide training and technical assistance for recipients on REDCap post-award.

a. Recipient Evaluation and Performance Measurement Plan (required)
With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

• Performance measures and targets
• The frequency that performance data are to be collected.
• How performance data will be reported.
• How quality of performance data will be assured.
• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
• Dissemination channels and audiences.
• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).
• The frequency that evaluations will be conducted.
• How evaluation reports will be published on a publically available website.
• How evaluation findings will be used to ensure continuous quality and program improvement.
• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
• Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

b. Annual Performance Report (APR) (required)

The recipient must submit the APR via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
    - Indirect Cost Rate Agreement.

The recipients must submit the Annual Performance Report via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period.

c. Performance Measure Reporting (optional)

CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for recipients at the beginning of the award period.

d. Federal Financial Reporting (FFR) (required)

The annual FFR form (SF-425) is required and must be submitted 90 days after the end of the budget period through the Payment Management System (PMS). The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)

The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

- https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf,
- https://www. fsrs.gov/documents /ffata_legislation_ 110_252.pdf
- http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA.

5. Reporting of Foreign Taxes (International/Foreign projects only)

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) ("United States foreign assistance funds"). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.

3) Terms: For purposes of this clause:
"Commodity" means any material, article, supplies, goods, or equipment;
"Foreign government" includes any foreign government entity;
"Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to [redacted]@cdc.gov.

5) Contents of Reports: The reports must contain:

a. recipient name;
b. contact name with phone, fax, and e-mail;
c. agreement number(s) if reporting by agreement(s);
d. reporting period;
e. amount of foreign taxes assessed by each foreign government;
f. amount of any foreign taxes reimbursed by each foreign government;
g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

6. Termination

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

(1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;

(2) By the HHS awarding agency or pass-through entity for cause;

(3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

First Name:
[redacted]
Last Name:
[redacted]
Address:

Department of Health and Human Services
[redacted]

Telephone:

Email:
[redacted]@cdc.gov

Grants Staff Contact

For **financial, awards management, or budget assistance,** contact:

First Name:
[redacted]

Last Name:
[redacted]

Address:

Department of Health and Human Services
[redacted]

Telephone:
[redacted]

Email:
[redacted]@cdc.gov

For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348

H. Other Information

Following is a list of acceptable attachments **applicants** can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative

- Budget Narrative
- CDC Assurances and Certifications
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:

References

[1] [redacted], et al. Engaging With Communities — Lessons (Re)Learned From COVID-19. Prev Chronic Dis 2020;17:200250. https://www.cdc.gov/pcd/issues/2020/20_0250.htm

2] US Centers for Disease Control and Prevention. COVID-19 cases, data, and surveillance: hospitalization and death by race/ethnicity. Accessed October 12, 2020. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

[redacted] racial disparities in testing, infection, hospitalization, and death: analysis of Epic data. Published September 16, 2020. Accessed October 12, 2020. https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-racial-disparities-testing-infection-hospitalization-death-analysis-epic-patient-data/

[redacted] The association of social determinants of health with COVID-19
mortality in rural and urban counties. Journal of Rural Health. 2021;1-9. https://doi.org/10.1111/jrh.12557

I. Glossary

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

Assistance Listings: A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.

Assistance Listings Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

CDC Assurances and Certifications: Standard government-wide grant application forms.

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established period of performance (i.e., extends the "life" of the award).

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. http:// www.cdc.gov /grants /additionalrequirements /index.html.

DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at http://fedgov.dnb.com/ webform/displayHomePage.do.

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These

activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

Health Inequities: Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

Healthy People 2030: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

Intergovernmental Review: Executive Order 12372 governs applications subject to Intergovernmental Review of Federal Programs. This order sets up a system for state and local governmental review of proposed federal assistance applications. Contact the state single point of contact (SPOC) to alert the SPOC to prospective applications and to receive instructions on the State's process. Visit the following web address to get the current SPOC list: https://www.whitehouse.gov/wp-content/uploads/2017/11/Intergovernmental_-Review-_SPOC_01_2018_OFFM.pdf.

Letter of Intent (LOI): A preliminary, non-binding indication of an organization's intent to submit an application.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

Maintenance of Effort: A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other non-government sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.

Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA): Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

Outcome: The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A “program” may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period

Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear,

consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.

Program Strategies: Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

Program Official: Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.

System for Award Management (SAM): The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

Work Plan: The summary of period of performance outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

NOFO-specific Glossary and Acronyms

Health equity (2) is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

Underserved communities refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life. Populations can include but are not limited to: African American, Latino, and Indigenous and Native American persons, Asian Americans and Pacific

Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural communities; and persons otherwise adversely impacted by persistent poverty or inequality (Definition modified from the *Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, January 20, 2021)*.

Exhibit M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 05/26/2021

Recipient Information

1. Recipient Name

California Department of Public Health
[redacted]

2. Congressional District of Recipient
06

3. Payment System Identifier (ID)
[redacted]

4. Employer Identification Number (EIN)
[redacted]

5. Data Universal Numbering System (DUNS)
[redacted]

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator
[redacted]

8. Authorized Official
[redacted]

Federal Agency Information

CDC Office [redacted]

9. Awarding Agency Contact Information
[redacted]

10. Program Official Contact Information
[redacted]

Federal Award Information

11. Award Number
[redacted]

12. Unique Federal Award Identification Number (FAIN)
[redacted]

13. Statutory Authority
317(K)(2) OF PHSA 42USC 247B(K)(2)

14. Federal Award Project Title
National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities

15. Assistance Listing Number
93.391

16. Assistance Listing Program Title
Activities to Support State, Tribal, Local and Territorial (STLT) Health Department Response to Public Health or Healthcare Crises

17. Award Action Type
New

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 06/01/2021 **- End Date** 05/31/2023	
20.	**Total Amount of Federal Funds Obligated by this Action**	$32,474,916.00
	20a. Direct Cost Amount	$31,952,480.00
	20b. Indirect Cost Amount	$522,436.00
21.	Authorized Carryover	$0.00
22.	Offset	$0.00
23.	Total Amount of Federal Funds Obligated this budget period	$0.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$32,474,916.00
26.	**Project Period Start Date** 06/01/2021 **- End Date** 05/31/2023	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	Not Available

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
[redacted]

30. Remarks

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 05/26/2021

Recipient Information

Recipient Name

California Department of Public Health
[redacted]

Congressional District of Recipient
06

Payment Account Number and Type
[redacted]

Employer Identification Number (EIN) Data
[redacted]

Universal Numbering System (DUNS)
[redacted]

Recipient's Unique Entity Identifier
Not Available

31. Assistance Type
Project Grant

32. Type of Award
Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$1,760,826.00
b. Fringe Benefits	$974,441.00
c. Total Personnel Costs	$2,735,267.00
d. Equipment	$0.00
e. Supplies	$36,261.00
f. Travel	$40,480.00
g. Construction	$0.00
h. Other	$851,969.00
i. Contractual	$28,288,503.00
j. TOTAL DIRECT COSTS	**$31,952,480.00**
k. INDIRECT COSTS	**$522,436.00**
l. TOTAL APPROVED BUDGET	**$32,474,916.00**
m. Federal Share	**$32,474,916.00**
n. Non-Federal Share	**$0.00**

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
[redacted]	[redacted]	OT	41.51	$32,474,916.00	[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]

FAIN# [redacted]

Federal Award Date: 05/26/2021

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

AWARD ATTACHMENTS

California Department of Public Health [redacted]

1. Terms and Conditions

Recipient: California Department of Public Health

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Non-research awards at https://www.cdc.gov/grants/federalregulationspolicies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number CDC-RFA-OT21-2103, entitled National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities, and application dated April 30, 2021, as may be amended, which are hereby made a part of this Non-research award, hereinafter referred to as the Notice of Award (NoA).

Approved Funding: Funding in the amount of $32,474,916 is approved for a two year performance and budget period, which is June 1, 2021 through May 31, 2023. All future funding will be based on satisfactory programmatic progress and the availability of funds.

The federal award amount is subject to adjustment based on total allowable costs incurred and/or the value of any third party in-kind contribution when applicable.

Note: Refer to the Payment Information section for Payment Management System (PMS) subaccount information.

Component/Project Funding: The NOFO provides for the funding of multiple components under this award. The approved component funding levels for this notice of award are:

NOFO Component	Amount
Base funding	$30,593,568
State Rural Carveout	$1,881,348

Coronavirus Disease 2019 (COVID-19) Funds: A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the "CARES Act") (P.L. 116-136); the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139); the Consolidated Appropriations Act and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 (P.L. 116-260) and/or the American Rescue Plan of 2021 [P.L. 117-2] agrees, as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health measures (e.g., social distancing, home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation.

In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS–CoV–2 or to diagnose a possible case of COVID–19. Such reporting shall be in accordance with

guidance and direction from HHS and/or CDC. HHS laboratory reporting guidance is posted at: https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf.

Further, consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the purpose of this award, and the underlying funding, the recipient is expected to provide to CDC copies of and/or access to COVID-19 data collected with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.

This award is contingent upon agreement by the recipient to comply with existing and future guidance from the HHS Secretary regarding control of the spread of COVID-19. In addition, recipient is expected to flow down these terms to any subaward, to the extent applicable to activities set out in such subaward.

Financial Assistance Mechanism: Grant

Pre-Award Costs: Pre-award costs dating back to March 15, 2021 – and directly related to the COVID-19 outbreak response are allowable.

FUNDING RESTRICTIONS AND LIMITATIONS

Indirect Costs:

Indirect costs are approved based on the negotiated indirect cost rate agreement dated September 18, 2020, which calculates indirect costs as follows, a Final is approved at a rate of 19.1% of the base, which includes, Salaries and Benefits. The effective dates of this indirect cost rate are from July 1, 2020 to June 30, 2021.

REPORTING REQUIREMENTS

Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the following addresses:

CDC, Office of Grants Services
[redacted]
[redacted]@cdc.gov (Include “Mandatory Grant Disclosures” in subject line)

AND

U.S. Department of Health and Human Services
Office of the Inspector General
[redacted]

Fax: [redacted] (Include "Mandatory Grant Disclosures" in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

Recipients must include this mandatory disclosure requirement in all subawards and contracts under this award.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

CDC is required to report any termination of a federal award prior to the end of the period of performance due to material failure to comply with the terms and conditions of this award in the OMB-designated integrity and performance system accessible through SAM (currently FAPIIS). (45 CFR 75.372(b)) CDC must also notify the recipient if the federal award is terminated for failure to comply with the federal statutes, regulations, or terms and conditions of the federal award. (45 CFR 75.373(b))

PAYMENT INFORMATION

The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application.

The grant document number identified on the bottom of Page 1 of the Notice of Award must be known in order to draw down funds.

PROGRAM OR FUNDING SPECIFIC CLOSEOUT REQUIREMENTS

The final programmatic report format required is the following.

Final Performance Progress and Evaluation Report: This report should include the information specified in the NOFO and is submitted 90 days following the end of the period of performance via www.grantsolutions.gov . At a minimum, the report will include the following:

- Statement of progress made toward the achievement of originally stated aims.
- Description of results (positive or negative) considered significant.
- List of publications resulting from the project, with plans, if any, for further publication.

Additional guidance may be provided by the GMS and found at:
https://www.cdc.gov/grants/alreadyhavegrant/Reporting.html

CDC Staff Contacts

Grants Management Specialist: The GMS is the federal staff member responsible for the day-to-day management of grants and cooperative agreements. The GMS is the primary contact of recipients for business and administrative matters pertinent to grant awards.

Program/Project Officer: The PO is the federal official responsible for monitoring the programmatic, scientific, and/or technical aspects of grants and cooperative agreements, as well as contributing to the effort of the award under cooperative agreements.

Grants Management Officer: The GMO is the federal official responsible for the business and other non-programmatic aspects of grant awards. The GMO is the only official authorized to obligate federal funds and is responsible for signing the NoA, including revisions to the NoA that change the terms and conditions. The GMO serves as the counterpart to the business officer of the recipient organization.

Exhibit N

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]

FAIN# [redacted]

Federal Award Date: 03/24/2025

Recipient Information

1. Recipient Name

Public Health, California Department of
1615 Capitol Ave
Chronic Disease Control Branch
Sacramento, CA 95814-5015
(916) 552-8264

2. Congressional District of Recipient

06

3. Payment System Identifier (ID)

[redacted]

4. Employer Identification Number (EIN)

[redacted]

5. Data Universal Numbering System (DUNS)

[redacted]

6. Recipient's Unique Entity Identifier (UEI)

[redacted]

7. Project Director or Principal Investigator

[redacted]

8. Authorized Official

[redacted]

Federal Agency Information

CDC [redacted]

9. Awarding Agency Contact Information

[redacted]

10.Program Official Contact Information

[redacted]

Federal Award Information

11. Award Number

[redacted]

12. Unique Federal Award Identification Number (FAIN)

[redacted]

13. Statutory Authority

317(K)(2) OF PHSA 42USC 247B(K)(2)

14. Federal Award Project Title

National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities

15. Assistance Listing Number

93.391

16. Assistance Listing Program Title

Activities to Support State, Tribal, Local and Territorial (STLT) Health Department Response to Public Health or Healthcare Crises

17. Award Action Type

Terminate

18. Is the Award R&D?

No

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 06/01/2021 **- End Date** 03/24/2025	
20.	**Total Amount of Federal Funds Obligated by this Action**	$0.00
	20a. Direct Cost Amount	$0.00
	20b. Indirect Cost Amount	$0.00
21.	Authorized Carryover	$0.00
22.	Offset	$0.00
23.	Total Amount of Federal Funds Obligated this budget period	$32,474,916.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$32,474,916.00
26.	**Period of Performance Start Date** 06/01/2021 **- End Date** 03/24/2025	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$32,474,916.00

28. Authorized Treatment of Program Income

ADDITIONAL COSTS

29. Grants Management Officer – Signature

[redacted]

30. Remarks

Department Authority

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# [redacted]

FAIN# [redacted]

Federal Award Date: 03/24/2025

Recipient Information

Recipient Name

Public Health, California Department of

[redacted]

Congressional District of Recipient

06

Payment Account Number and Type

[redacted]

Employer Identification Number (EIN) Data

[redacted]

Universal Numbering System (DUNS)

[redacted]

Recipient's Unique Entity Identifier (UEI)

[redacted]

31. Assistance Type

Project Grant

32. Type of Award

Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only

II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$1,760,826.00
b. Fringe Benefits	$974,441.00
c. Total Personnel Costs	$2,735,267.00
d. Equipment	$0.00
e. Supplies	$36,261.00
f. Travel	$40,480.00
g. Construction	$0.00
h. Other	$851,969.00
i. Contractual	$28,288,503.00
j. TOTAL DIRECT COSTS	**$31,952,480.00**
k. INDIRECT COSTS	**$522,436.00**
l. TOTAL APPROVED BUDGET	**$32,474,916.00**
m. Federal Share	**$32,474,916.00**
n. Non-Federal Share	**$0.00**

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	ASSISTANCE LISTING	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
[redacted]		OT	41.51	93.391	$0.00	[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES Notice of Award

Centers for Disease Control and Prevention

Award# [redacted]
FAIN# [redacted]
Federal Award Date: 03/24/2025

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

AWARD ATTACHMENTS

Public Health, California Department of [redacted]

1. Termination Action TC – FINAL

TERMS AND CONDITIONS OF AWARD

Termination: The purpose of this amendment is to terminate this award which is funded by COVID-19 supplemental appropriations. The termination of this award is for cause. HHS regulations permit termination if "the non-Federal entity fails to comply with the terms and conditions of the award", or separately, "for cause." The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out. Termination of this award is effective as of the date set out in your Notice of Award.

No additional activities can be conducted, and no additional costs may be incurred. Unobligated award balances will be de-obligated by CDC.

Closeout: In order to facilitate an orderly closeout, we are requesting that you submit all closeout reports identified below within thirty (30) days of the date of this NoA. Submit the documentation as a "Grant Closeout" amendment in GrantSolutions. The reporting timeframe is the full period of performance. Please note, if you fail to submit timely and accurate reports, CDC may also pursue other enforcement actions per 45 CFR Part 75.371.

Final Performance/Progress Report: This report should include the information specified in the Notice of Funding Opportunity (NOFO). At a minimum, the report will include the following:

- Statement of progress made toward the achievement of originally stated aims.
- Description of results (positive or negative) considered significant.
- List of publications resulting from the project, with plans, if any, for further publication.

Final Federal Financial Report (FFR, SF-425): The FFR should only include those funds authorized and expended during the timeframe covered by the report. The final report must indicate the exact balance of unobligated funds and may not reflect any unliquidated obligations. Should the amount not match with the final expenditures reported to the Payment Management System (PMS), you will be required to update your reports to PMS accordingly.

Equipment and Supplies - Tangible Personal Property Report (SF-428): A completed SF-428 detailing all major equipment acquired with a unit acquisition cost of $10,000 or more. If no equipment was acquired under the award, a negative report is required